APPENDIX H: CITATION TABLE FOR THE KEY ELEMENTS OF THE PMT

Yellow=revised; Blue =addition

WORKSHEET 1: *QUALITY MANAGEMENT*

KEY ELEMENTS	CITATIONS
1A. The provider has a current written quality management plan that is shared with staff and integrates QA/QI throughout the organization.	10A NCAC 27G .0201: GOVERNING BODY POLICIES: [a] The governing body responsible for each facility or service shall develop and implement written policies for the following:… (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan (C) methods for monitoring & evaluating the quality and appropriateness of client care, including delineation of client outcomes & utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service;* (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges; (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;… * Note: Except for CAP-MR/DD as noted in Implementation Update #51, supervision of a paraprofessional is carried out by a QP or an AP, or unless otherwise specified by the requirements in the service definition. See 10A NCAC 27G .0104 STAFF DEFINITIONS (15), in Key Element 3A in Worksheet 3 below. 10A NCAC 27G .0609: LOCAL MANAGEMENT ENTITY REPORTING REQUIREMENTS: (a) As part of its quality improvement process as set forth in Rule .0201(a)(7) of this Subchapter, the LME shall review, not less than quarterly, patterns and trends in: (1) level I, level II and level III incidents; (2) complaints concerning the provision of public services; and (3) local monitoring results gathered pursuant to requirements established in 10A NCAC 27G .0608. (b) The LME shall provide reports based on the review specified in Paragraph (a) of this Rule. The reports shall be submitted via electronic means to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services quarterly on forms provided by the Secretary. Copies of the reports shall be provided to the LME's area board, local Consumer and Family Advisory Committee, established by G.S. 122C-170, and the local Client Rights Committee, established by Rule .0504 of this Subchapter. (c) The reports shall include the following: (1) summary numbers of the types of complaints, incidents and results of local monitoring; (2) trends identified through analyses of complaints, incidents and local monitoring; and (3) use of the analyses for improvement of the service system and planning of future monitoring activities. CONTRACT BETWEEN LME AND PROVIDER AGENCY FOR STATE-FUNDED MH/DD/SA SERVICES – 6/13/07: 2.6 Quality Management: Provider shall conduct a quality management program in accordance with the DHHS policies and agrees to provide evidence of assessment of quality of care and best practices, effectiveness and satisfaction with services to the LME upon request. Provider shall abide by the treatment protocols, requirements for person-centered planning and implement evidence-based practices as defined and adopted by the Division of MH/DD/SA and any subsequent revisions. Provider shall ensure that corrective action is taken on a timely basis to address problems found through the quality management process.

[continuation] 1A. The provider has a current written quality management plan that is shared with staff and integrates QA/QI throughout the organization.	AGREEMENT BETWEEN LME AND DIRECT-ENROLLED PROVIDERS OF ENHANCED MH/DD/SA SERVICES FOR MEDICAID – UPDATED 5/15/06: 2.6 Quality Management: Provider of enhanced benefits shall conduct a quality management program in accordance with the DHHS policies and agrees to provide evidence of assessment of quality of care and best practices, effectiveness and satisfaction with services to the Area Authority/County Program upon request. Provider shall abide by the treatment protocols, requirements for person-centered planning and implement evidence-based practices as defined and adopted by the Division of MHDDSA and any subsequent revisions. Provider shall ensure that corrective action is taken on a timely basis to address problems found through the quality management process. IMPLEMENTATION UPDATE # 32: ACCESSSING CARE AND OTHER TOPICS…: Minimum Requirements for Compliance for Payment: Per their Medicaid contract, providers have accepted the responsibilities for understanding the definition of each service they are enrolled to deliver and for being accountable for the funds received. This means that staff is fully trained on the goals and objectives of the service and the strategies and techniques used at a macro level. Furthermore, they know how to apply these to the individual needs of the consumers. They are responsible for making sure that consumers and families understand the purpose of the service or services they are receiving and the consequences of their choices. Providers are also responsible for all data collection and documentation requirements as well. Likewise, a provider's business staff must know that the requirements are met for appropriate documentation, forms, prior authorizations, staff qualifications, and other quality assurance functions. All documentation supports the legitimacy of the billing. Quality assurance is an ongoing process. Clinical reviews and supervision are critical to a quality provider system. It is also important to know the reasons for denials of payment, make corrections as appropriate, and then resubmit… Recommendations to Providers: ▪ Check the DMH/DD/SAS web site regularly. This is the single most important source of information and provides links to needed information on the DMA web site ▪ Read the DMA Medicaid Bulletins that are posted to the DMA web site the first of each month. ▪ Check the DMA web site for news on EDS and ValueOptions ▪ Quality assurance is an ongoing process. Conduct self assessments and post payment reviews. You can pay back to Medicaid without penalty...
1B. The quality management committee is actively involved in the provider's QA/QI activities.	10A NCAC 27G .0201: GOVERNING BODY POLICIES: [See citation in Key Element 1A. above.]
1C. The provider has a QM committee and uses data to monitor quality, develop/ implement improvement initiatives, monitor progress, and make needed adjustments.	10A NCAC 27G .0201: GOVERNING BODY POLICIES.: [See citation in Key Element 1A. above.] 10A NCAC 27G .0609: LOCAL MANAGEMENT ENTITY REPORTING REQUIREMENTS: (a) As part of its quality improvement process as set forth in Rule .0201(a)(7) of this Subchapter, the LME shall review, not less than quarterly, patterns and trends in: (1) level I, level II and level III incidents; (2) complaints concerning the provision of public services; and (3) local monitoring results gathered pursuant to requirements established in 10A NCAC 27G .0608. (b) The LME shall provide reports based on the review specified in Paragraph (a) of this Rule. The reports shall be submitted via electronic means to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services quarterly on forms provided by the Secretary. Copies of the reports shall be provided to the LME's area board, local Consumer and Family Advisory Committee, established by G.S. 122C-170, and the local Client Rights Committee, established by Rule .0504 of this Subchapter. (c) The reports shall include the following: (1) summary numbers of the types of complaints, incidents and results of local monitoring; (2) trends identified through analyses of complaints, incidents and local monitoring; and (3) use of the analyses for improvement of the service system and planning of future monitoring activities.

1D. The provider uses incident/complaint data for identifying and mitigating systemic risk issues.	10A NCAC 27G .0601 SCOPE (a) This Section governs Local Management Entity (LME) monitoring of the provision of public services in the LME's catchment area. (b) The LME shall monitor the provision of public services in the LME's catchment area. (c) The LME shall develop and implement written policies governing monitoring of the provision of public services that include: (1) receiving, reviewing and responding to level II and level III incident reports as set forth in Rules .0603, .0604, and .0605 of this Section; (2) receiving and responding to complaints concerning the provision of public services, as set forth in Rule .0606 of this Section; (3) conducting local monitoring of Category A and B providers of public services as set forth in Rule .0608 of this Section; and (4) analyzing and reporting trends in the information identified in Subparagraphs (c)(1) through (c)(3) of this Rule, as set forth in Rule .0608 of this Section. (d) An LME or provider of public services shall exchange information, including confidential information, when necessary to coordinate and carry out the monitoring functions as set forth in this Section. Sharing of information shall conform to 42 CFR, Part 2 for persons receiving Substance Abuse Services. The exchange of information shall apply as follows: (1) an LME to another LME; (2) an LME to a provider of public services; (3) a provider of public services to an LME; (4) a provider of public services to another provider of public services; (5) a provider of public services to the Department; (6) an LME to the Department; (7) the Department to an LME; and (8) the Department to a provider of public services. 10A NCAC 27G .0602 DEFINITIONS In addition to the terms defined in G.S. 122C-3 and Rules .0103 and .0104 of this Subchapter, the following terms shall apply to the rules in this Section: (1) “Complaint investigation" means the process of determining if an allegation made against a provider concerning the provision of public services is substantiated. (2) "ICF/MR" means a facility certified for Medicaid as an Intermediate Care Facility for the Mentally Retarded. (3) "Level I incident" means the same as defined in 10A NCAC 27G .0103(b)(32) and does not meet the definition of a level II incident or level III incident. (4) "Level II incident" means the same as defined in 10A NCAC 27G .0103(b)(32), including a client death due to natural causes or terminal illness, or results in a threat to a client's health or safety, or a threat to the health or safety of others due to client behavior and does not meet the definition of a level III incident. (5) "Level III incident" means the same as defined in 10A NCAC 27G .0103(b)(32) and results in: (a) a death, sexual assault, or permanent physical or psychological impairment to a client; (b) a substantial risk of death, or permanent physical or psychological impairment to a client; (c) a death, sexual assault, permanent physical or psychological impairment caused by a client; (d) a substantial risk of death or permanent physical or psychological impairment caused by a client; or (e) a threat caused by a client to a person's safety. (6) "Local Monitoring" means LME monitoring of the provision of public services in its catchment area that are provided by Category A and B providers. (7) "Monitor" or "Monitoring" means the interaction between the LME and a provider of public services regarding the functions set forth in Rule .0601(c) of this Section. (8) "Provider category" means the type of facility in which a client receives services or resides. The provider category determines the extent of monitoring that a provider receives and is determined as follows: (a) Category A - facilities licensed pursuant to G.S. 122C, Article 2, except for hospitals. These include 24-hour residential facilities, day treatment, PRTFs and outpatient services; (b) Category B – G.S. 122C, Article 2, community based providers not requiring State licensure; (c) Category C - hospitals, state-operated facilities, nursing homes, adult care homes, family care homes, foster care homes or child care facilities; and (d) Category D - individuals providing only outpatient or day services and who are licensed or certified to practice in the State of North Carolina.

[continuation] 1D. The provider uses incident/complaint data for identifying and mitigating systemic risk issues.	10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:

[continuation] 1D. The provider uses incident/complaint data for identifying and mitigating systemic risk issues. .	(1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. <u>10A NCAC 27G .0606 REFERRAL OF COMPLAINTS TO LOCAL MANAGEMENT ENTITIES PERTAINING TO CATEGORY A OR CATEGORY B PROVIDERS</u> (a) The Local Management Entity shall respond to complaints received concerning the provision of public services or client rights pertaining to Category A and B providers within its catchment area. (b) When the Local Management Entity is a subject of the complaint, the LME shall refer the complaint concerning a Category A provider to the Division of Health Service Regulation, or a Category B provider to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. (c) When the LME receives a complaint concerning a Category A provider, and the complaint is related to a North Carolina rule, the LME shall forward the complaint directly to the Division of Health Service Regulation. (d) When the LME receives a complaint concerning a community-based ICF/MR, the LME shall forward the complaint directly to the Division of Health Service Regulation. The Division of Health Service Regulation is responsible for the complaint investigation. (e) When a complaint investigation involving a Category B provider identifies an issue which if substantiated by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services could result in a revocation or suspension of the provider's funding pursuant to 10A NCAC 26C .0501 through .0504, the LME shall document the issue or issues creating the concern and notify the Division of Mental Health, Developmental Disabilities and Substance Abuse Services of the issue within 24 hours. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services shall consult with the LME, and shall then determine which agency will lead the investigation and which agencies need to be involved. Separate complaint investigations shall not be performed. (f) When a complaint investigation results in the Local Management Entity initiating action to withdraw endorsement of a provider endorsed by the Local Management Entity, the LME shall follow the requirements identified in 10A NCAC 26C .0709.

[continuation] 1D. The provider uses incident/complaint data for identifying and mitigating systemic risk issues.	(g) When facilities employ contract clinical staff to perform clinical functions as a component of the service provided by the provider, the Local Management Entity may investigate a complaint concerning the contracted clinician only if the complaint involves an individual being served in the context of the publicly funded service. 10A NCAC 27G .0609: LOCAL MANAGEMENT ENTITY REPORTING REQUIREMENTS: [See citation in Key Element 1A. above.] SECTION .7000 – LOCAL MANAGEMENT ENTITY RESPONSE TO COMPLAINTS 10A NCAC 27G .7001 SCOPE (a) The rules in this Section govern the Local Management Entity responses to complaints received concerning the provision of public services pertaining to all provider categories in its catchment area. (b) The rules in this Section also govern the procedures for Local Management Entities when investigating providers according to 10A NCAC 27G .0606. 10A NCAC 27G .7002 LOCAL MANAGEMENT ENTITY REQUIREMENTS CONCERNING COMPLAINTS (a) A Local Management Entity shall respond to complaints received concerning the provision of public services pertaining to all provider categories, as defined in 10A NCAC 27G .0602(8), in its catchment area. This Rule does not govern complaints pertaining to utilization review decisions. (b) The Local Management Entity shall: (1) establish a written notification procedure to inform each client of the complaint process concerning the provision of public services. The procedure shall include the provision of written information explaining the client's right to contact the Local Management Entity, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the Division of Health Service Regulation, the Division of Social Services and The North Carolina Protection and Advocacy system known as Disability Rights North Carolina; (2) seek to resolve issues of concern through informal agreement between the client and the provider and document the attempts at resolution; (3) develop and implement written policies including those safeguards and procedures listed below: (A) safeguards for protecting the identity of the complainant; (B) safeguards for protecting the complainant and any staff person from harassment or retaliation; (C) procedures to receive and track complaints; (D) procedures to assist a client in initiating the complaint process; (E) procedures for encouraging the complainant to communicate with the provider to allow for resolution of the issue; (F) methods to be used in investigating a complaint; (G) procedures for responding to complaints and options to be considered in resolving a complaint, including corrective action and referral to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the Division of Health Service Regulation, the Division of Social Services or other agencies as required; (H) procedures governing complaints and appeals made by a provider and a complainant; (I) procedures for notifying the home Local Management Entity, if different, of the complaint and actions taken; and (J) procedures for the Local Management Entity Director to convene an ad hoc appeal review committee to review client and provider appeals. The client rights committee, as defined in 10A NCAC 27G .0504, shall approve policy and procedures regarding the formation of the appeal review committee including assurance of the review committee's lack of conflict of interest, composition, disability affiliation(s) and other experience or qualifications relevant to the issue(s) in the complaint. The committee's recommendations shall be by majority vote; (4) review the complaint and communicate to the complainant within five working days of receipt whether the complaint will be addressed informally or by conducting an investigation; and (5) notify the complainant in writing of the results of the informal process in a letter dated within 15 working days from (6) receipt of the complaint. If the need for an investigation is revealed during the informal process, the Local Management Entity shall begin the investigation or refer the matter to the appropriate State or local government agency. If the complainant is not satisfied with the informal process, the complainant may file an appeal in writing to the Local Management Entity Director. The appeal must be received within 15 working days from the date of the informal resolution letter. The Local Management Entity Director shall:

[continuation] 1D. The provider uses incident/complaint data for identifying and mitigating systemic risk issues.	(A) convene an appeal review committee according to Part (b)(3)(J) of this Rule; and (B) issue an independent decision after reviewing the appeal review committee's recommendation. The decision shall be dated and mailed to the appellant by the Local Management Entity within 20 working days from receipt of the appeal. (c) When the Local Management Entity refers the complaint to the State or local government agency responsible for the regulation and oversight of the provider, the Local Management Entity shall send a letter to the complainant informing him or her of the referral and the contact person at the agency where the referral was made. The Local Management Entity shall contact the State or local government agency where the referral was made within 80 working days of the date the Local Management Entity received the complaint to determine the actions the State or local government agency has taken in response to the complaint. The Local Management Entity shall communicate the status of the State or local government agency's response to the complainant and to the client's home Local Management Entity, if different. 10A NCAC 27G .7003 REQUIREMENTS FOR LOCAL MANAGEMENT ENTITY COMPLAINT INVESTIGATIONS (a) The Local Management Entity shall follow these procedures when investigating providers according to 10A NCAC 27G .0606: (1) The Local Management Entity shall make contact with the provider when investigating a complaint. The Local Management Entity shall state the purpose of the contact and inform the provider that the Local Management Entity is in receipt of a complaint concerning the provider and the general nature of the complaint. (2) The Local Management Entity shall complete the complaint investigation within 30 calendar days of the date of the receipt of the complaint. (3) Upon completion of the complaint investigation, the Local Management Entity shall submit a report of investigation findings to the complainant, the provider and client's home Local Management Entity, if different. The report shall be submitted within 15 calendar days of the date of completion of the investigation. The complaint investigation report shall include: (A) statements of the allegations or complaints lodged; (B) steps taken and information reviewed to reach conclusions about each allegation or complaint; (C) conclusions reached regarding each allegation or complaint; (D) citations of statutes and rules pertinent to each allegation or complaint; and (E) required action regarding each allegation or complaint. (4) The provider shall submit a plan of correction to the Local Management Entity for each issue requiring correction identified in the report in a letter dated 15 calendar days from the date the provider receives the complaint investigation report. (5) The Local Management Entity shall review and respond in writing to the provider's plan of correction with approval or a description of additional required information. The Local Management Entity shall respond to the provider in a letter dated 15 calendar days of receipt of the plan of correction. (6) The provider shall implement a plan of correction within 60 calendar days from the date of the complaint investigation report. (7) The complainant or provider who disagrees with the results of the Local Management Entity actions may file an appeal regarding the investigation that is received by the Local Management Entity within 21 calendar days from the receipt of the Local Management Entity investigation report. The Local Management Entity shall provide notification of the appeal to the complainant or provider to inform them of this appeal. The appeal is limited to items identified in the original complaint record and the investigation report. (8) The Local Management Entity shall convene a review committee to review the appeal as specified in 10A NCAC 27G .7002(b)(3)(J). (9) The Local Management Entity Director shall issue a written decision based on the appeal committee's decision to uphold or overturn the findings of the investigation. The decision letter shall be dated within 28 calendar days from receipt of the appeal. (10) The Local Management Entity shall follow-up on issues requiring correction in the investigation report no later than 60 calendar days from the date the plan of correction is approved. (11) When a complaint investigation involving a category B provider identifies an issue which if substantiated by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services could result in a revocation or suspension of the provider's funding pursuant to 10A NCAC 26C .0501 through .0504, the LME shall document the issue or issues creating the concern and notify the Division of Mental Health, Developmental Disabilities and Substance Abuse Services of the issue within 24 hours. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services shall consult with the Local Management Entity and then shall determine which agency will lead the investigation and which agencies need to be involved. Separate complaint investigations shall not be performed.

[continuation] 1D. The provider uses incident/complaint data for identifying and mitigating systemic risk issues.	(12) Local Management Entity shall provide information regarding the disposition of the complaint to the complainant and the client's home Local Management Entity, if different, as soon as the investigation is concluded. (b) The Local Management Entity shall maintain copies of complaint investigations, resolutions and follow-up reports for providers for review by the Department of Health and Human Services.
1E. The provider has a system to protect and review the rights of individuals for service improvement.	CONTRACT BETWEEN LME AND PROVIDER AGENCY FOR STATE-FUNDED MH/DD/SA SERVICES – 6/13/07: 2.3 Rights of Individuals: Provider shall conduct activities in a manner that shall deter, prevent, and avoid abuse, neglect, and/or exploitation of individuals in its care and to ensure compliance with all DHHS and Federal requirements and in accordance with the policies of the LME. The Provider agrees to maintain policies, procedures and monitoring as required in the DHHS Client Right's policy, the Operations Manual and the policies of the LME. AGREEMENT BETWEEN LME AND DIRECT-ENROLLED PROVIDERS OF ENHANCED MH/DD/SA SERVICES FOR MEDICAID – UPDATED 5/15/06: 2.3 Rights of Individuals: Provider shall conduct activities in a manner that shall deter, prevent, and avoid abuse, neglect, and/or exploitation of individuals in its care and to ensure compliance with all DHHS and Federal requirements and in accordance with the policies of Area Authority/County Program. The Enhanced Benefit Provider agrees to maintain policies, procedures and monitoring as required in the DHHS Client Right's policy, the Operations Manual and the policies of Area Authority/County Program. **GENERAL RIGHTS:** 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS: (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. (f) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policies which require that: (1) positive alternatives and less restrictive interventions are considered and are used whenever possible prior to the use of more restrictive interventions; and

[continuation] 1E. The provider has a system to protect and review the rights of individuals for service improvement.	(2) consideration is given to the client's physical and psychological well-being before, during and after utilization of a restrictive intervention, including: (A) review of the client's health history or the comprehensive health assessment conducted upon admission to a facility. The health history or comprehensive health assessment shall include the identification of pre-existing medical conditions or any disabilities and limitations that would place the client at greater risk during the use of restrictive interventions; (B) continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of physical restraint throughout the duration of the restrictive intervention by staff who are physically present and trained in the use of emergency safety interventions; (C) continuous monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being during the use of manual restraint; and (D) continued monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a restrictive intervention; and (3) following the utilization of a restrictive intervention, staff shall conduct debriefing and planning with the client and the legally responsible person, if applicable, as specified in 10A NCAC 27E .0104, to eliminate or reduce the probability of the future use of restrictive interventions. Debriefing and planning shall be conducted, as appropriate, to the level of cognitive functioning of the client. 10A NCAC 27D .0102 : SUSPENSION AND EXPULSION POLICY: (a) Each client shall be free from threat or fear of unwarranted suspension or expulsion from the facility. (b) The governing body shall develop and implement policy for suspension or expelling a client from a service. The policy shall address the criteria to be used for an suspension, expulsion or other discharge not mutually agreed upon and shall establish documentation requirements that include: (1) the specific time and conditions for resuming services following suspension; (2) efforts by staff of the facility to identify an alternative service to meet the client's needs and designation of such service; and (3) the discharge plan, if any. 10A NCAC 27D .0103 SEARCH AND SEIZURE POLICY (a) Each client shall be free from unwarranted invasion of privacy. (b) The governing body shall develop and implement policy that specifies the conditions under which searches of the client or his living area may occur, and if permitted, the procedures for seizure of the client's belongings, or property in the possession of the client. (c) Every search or seizure shall be documented. Documentation shall include: (1) scope of search; (2) reason for search; (3) procedures followed in the search; (4) a description of any property seized; and (5) an account of the disposition of seized property. 10A NCAC 27D .0104 PERIODIC INTERNAL REVIEW: (a) The governing body shall assure the conduct, no less than every three years, of a compliance review in each of its facilities regarding the implementation of Client Rights Rules as specified in 10A NCAC 27C, 27D, 27E and 27F. (b) The review shall assure that: (1) there is compliance with applicable provisions of the federal law governing advocacy services to the mentally ill, as specified in the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (Public Law 99-319) and amended by Public Law 100-509 (1988); and (2) there is compliance with applicable provisions of the federal laws governing advocacy services to the developmentally disabled, the Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. 6000 et. seq. (c) The governing body shall maintain the three most recent written reports of the findings of such reviews. 10A NCAC 27D .0201 INFORMING CLIENTS (a) A written summary of client rights as specified in G.S. 122C, Article 3 shall be made available to each client and legally responsible person. (b) Each client shall be informed of his right to contact the Governor's Advocacy Council for Persons with Disabilities (GACPD),

[continuation] 1E. The provider has a system to protect and review the rights of individuals for service improvement.	the statewide agency designated under federal and State law to protect and advocate the rights of persons with disabilities. (c) Each client shall be informed regarding the issues specified in Paragraph (d) and, if applicable in Paragraph (e), of this Rule, upon admission or entry into a service, or (1) in a facility where a day/night or periodic service is provided, within three visits; or (2) in a 24-hour facility, within 72 hours. Explanation shall be in a manner consistent with the client's or legally responsible person's level of comprehension. (d) In each facility, the information provided to the client or legally responsible person shall include; (1) the rules that the client is expected to follow and possible penalties for violations of the rules; (2) the client's protections regarding disclosure of confidential information, as delineated in G.S. 122C-52 through G.S. 122C-56; (3) the procedure for obtaining a copy of the client's treatment/habilitation plan; and (4) governing body policy regarding: (A) fee assessment and collection practices for treatment/habilitation services; (B) grievance procedures including the individual to contact and a description of the assistance the client will be provided; (C) suspension and expulsion from service; and (D) search and seizure. (e) In addition, for the client whose treatment/habilitation is likely to include the use of restrictive interventions, or for the client in a 24-hour facility whose rights as specified in G.S. 122C-62 (b) or (d) may be restricted, the client or legally responsible person shall also be informed: (1) of the purposes, goals and reinforcement structure of any behavior management system that is allowed; (2) of potential restrictions or the potential use of restrictive interventions; (3) of notification provisions regarding emergency use of restrictive intervention procedures; (4) that the legally responsible person of a minor or incompetent adult client may request notification after any occurrence of the use of restrictive intervention; (5) that the competent adult client may designate an individual to receive notification, in accordance with G.S. 122C-53(a), after any occurrence of the use of restrictive intervention; and (6) of notification provisions regarding the restriction of client rights as specified in G.S. 122C-62(e). (f) There shall be documentation in the client record that client rights have been explained. <u>10A NCAC 27D .0202 INFORMING STAFF</u>: The governing body shall develop and implement policy to assure that all staff are kept informed of the rights of clients as specified in 122C, Article 3, all applicable rules, and policies of the governing body. Documentation of receipt of information shall be signed by each staff member and maintained by the facility. <u>10A NCAC 27D .0301 SOCIAL INTEGRATION</u> Each client in a day/night or 24-hour facility shall be encouraged to participate in appropriate and generally acceptable social interactions and activities with other clients and non-client members of the community. A client shall not be prohibited from such social interactions unless restricted in writing in the client record in accordance with G.S. 122C-62(e). <u>10A NCAC 27D .0302 CLIENT SELF-GOVERNANCE</u> In a day/night or 24-hour facility, the governing body shall develop and implement policy which allows client input into facility governance and the development of client self-governance groups. <u>10A NCAC 27D .0303 INFORMED CONSENT</u> (a) Each client, or legally responsible person, shall be informed, in a manner that the client or legally responsible person can understand, about: (1) the alleged benefits, potential risks, and possible alternative methods of treatment/habilitation; and (2) the length of time for which the consent is valid and the procedures that are to be followed if he chooses to withdraw consent. The length of time for a consent for the planned use of a restrictive intervention shall not exceed six months. (b) A consent required in accordance with G.S. 122C-57(f) or for planned interventions specified by the rules in Subchapter 27E, Section .0100, shall be obtained in writing. Other procedures requiring written consent shall include, but are not limited to, the prescription or administration of the following drugs: (1) Antabuse; and

[continuation] 1E. The provider has a system to protect and review the rights of individuals for service improvement. .	(2) Depo-Provera when used for non-FDA approved uses. (c) Each voluntary client or legally responsible person has the right to consent or refuse treatment/habilitation in accordance with G.S. 122C-57(d). A voluntary client's refusal of consent shall not be used as the sole grounds for termination or threat of termination of service unless the procedure is the only viable treatment/habilitation option available at the facility. (d) Documentation of informed consent shall be placed in the client's record. 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. **TREATMENT OR HABILITATION RIGHTS:** 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use. . 10A NCAC 27E .0102 PROHIBITED PROCEDURES In each facility the following types of procedures shall be prohibited: (1) those interventions which have been prohibited by statute or rule which shall include: (a) any intervention which would be considered corporal punishment under G.S. 122C-59; (b) the contingent use of painful body contact; (c) substances administered to induce painful bodily reactions, exclusive of Antabuse; (d) electric shock (excluding medically administered electroconvulsive therapy); (e) insulin shock; (f) unpleasant tasting foodstuffs; (g) contingent application of any noxious substances which include but are not limited to noise, bad smells or splashing with water; and (h) any potentially physically painful procedure, excluding prescribed injections, or stimulus which is administered to the client for the purpose of reducing the frequency or intensity of a behavior. (2) those interventions determined by the governing body to be unacceptable for or prohibited from use in the facility. 10A NCAC 27E .0103 GENERAL POLICIES REGARDING INTERVENTION PROCEDURES (a) The following procedures shall only be employed when clinically or medically indicated as a method of therapeutic treatment: (1) planned non-attention to specific undesirable behaviors when those behaviors are health threatening; (2) contingent deprivation of any basic necessity; or (3) other professionally acceptable behavior modification procedures that are not prohibited by Rule .0102 of this Section or covered by Rule .0104 of this Section. (b) The determination that a procedure is clinically or medically indicated, and the authorization for the use of such treatment for a specific client, shall only be made by either a physician or a licensed practicing psychologist who has been formally trained and privileged in the use of the procedure.

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The provider has a system to protect and review the rights of individuals for service improvement.

10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT, ISOLATION TIME-OUT & PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL

(a) This Rule governs the use of restrictive interventions which shall include:
  (1) seclusion;
  (2) physical restraint;
  (3) isolation time-out;
  (4) any combination thereof; and
  (5) protective devices used for behavioral control.

(b) The use of restrictive interventions shall be limited to:
  (1) emergency situations, in order to terminate a behavior or action in which a client is in imminent danger of abuse or injury to self or other persons or when property damage is occurring that poses imminent risk of danger of injury or harm to self or others; or
  (2) as a planned measure of therapeutic treatment as specified in Paragraph (f) of this Rule.

(c) Restrictive interventions shall not be employed as a means of coercion, punishment or retaliation by staff or for the convenience of staff or due to inadequacy of staffing. Restrictive interventions shall not be used in a manner that causes harm or abuse.

(d) In accordance with Rule .0101 of Subchapter 27D, the governing body shall have policy that delineates the permissible use of restrictive interventions within a facility.

(e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions:
  (1) the requirement that positive and less restrictive alternatives are considered and attempted whenever possible prior to the use of more restrictive interventions;
  (2) consideration is given to the client's physical and psychological well-being before, during and after utilization of a restrictive intervention, including:
    (A) review of the client's health history or the client's comprehensive health assessment conducted upon admission to a facility. The health history or comprehensive health assessment shall include the identification of pre-existing medical conditions or any disabilities and limitations that would place the client at greater risk during the use of restrictive interventions;
    (B) continuous assessment and monitoring of the physical and psychological well- being of the client and the use of restraint throughout the duration of the restrictive intervention by staff who are physically present and trained in the use of emergency safety interventions;
    (C) continuous monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being during the use of manual restraint; and
    (D) continued monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a restrictive intervention;
  (3) the process for identifying, training, assessing competence of facility employees who may authorize and implement restrictive interventions;
  (4) the duties and responsibilities of responsible professionals regarding the use of restrictive interventions;
  (5) the person responsible for documentation when restrictive interventions are used;
  (6) the person responsible for the notification of others when restrictive interventions are used; and
  (7) the person responsible for checking the client's physical and psychological well-being and assessing the possible consequences of the use of a restrictive intervention and, in such cases there shall be procedures regarding:
    (A) documentation if a client has a physical disability or has had surgery that would make affected nerves & bones sensitive to injury; and
    (B) the identification and documentation of alternative emergency procedures, if needed;
  (8) any room used for seclusion or isolation time-out shall meet the following criteria:
    (A) the room shall be designed and constructed to ensure the health, safety and well-being of the client;
    (B) the floor space shall not be less than 50 square feet, with a ceiling height of not less than eight feet;
    (C) the floor and wall coverings, as well as any contents of the room, shall have a one-hour fire rating and shall not produce toxic fumes if burned;
    (D) the walls shall be kept completely free of objects;
    (E) a lighting fixture, equipped with a minimum of a 75 watt bulb, shall be mounted in the ceiling and be screened to prevent tampering by the client;

[continuation] 1E. The provider has a system to protect and review the rights of individuals for service improvement.	(F) one door of the room shall be equipped with a window mounted in a manner which allows inspection of the entire room; (G) glass in any windows shall be impact resistant and shatterproof; (H) the room temperature and ventilation shall be comparable and compatible with the rest of the facility; and (I) in a lockable room the lock shall be interlocked with the fire alarm system so that the door automatically unlocks when the fire alarm is activated if the room is to be used for seclusion. (9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum: (A) notation of the client's physical and psychological well-being; (B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior; (C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used; (D) a description of the intervention and the date, time and duration of its use; (E) a description of accompanying positive methods of intervention; (F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions; (G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and (H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention. (10) The emergency use of restrictive interventions shall be limited, as follows: (A) a facility employee approved to administer emergency interventions may employ such procedures for up to 15 minutes without further authorization; (B) the continued use of such interventions shall be authorized only by the responsible professional or another qualified professional who is approved to use and to authorize the use of the restrictive intervention based on experience and training; (C) the responsible professional shall meet with and conduct an assessment that includes the physical and psychological well-being of the client and write a continuation authorization as soon as possible after the time of initial employment of the intervention. If the responsible professional or a qualified professional is not immediately available to conduct an assessment of the client, but concurs that the intervention is justified after discussion with the facility employee, continuation of the intervention may be verbally authorized until an on-site assessment of the client can be made; (D) a verbal authorization shall not exceed three hours after the time of initial employment of the intervention; and (E) each written order for seclusion, physical restraint or isolation time-out is limited to four hours for adult clients; two hours for children and adolescent clients ages nine to 17; or one hour for clients under the age of nine. The original order shall only be renewed in accordance with these limits or up to a total of 24 hours. (11) The following precautions and actions shall be employed whenever a client is in: (A) seclusion or physical restraint, including a protective device when used for the purpose or with the intent of controlling unacceptable behavior: periodic observation of the client shall occur at least every 15 minutes, or more often as necessary, to assure the safety of the client, attention shall be paid to the provision of regular meals, bathing & the use of the toilet; and such observation & attention shall be documented in the client record; (B) isolation time-out: there shall be a facility employee in attendance with no other immediate responsibility than to monitor the client who is placed in isolation time-out; there shall be continuous observation and verbal interaction with the client when appropriate; and such observation shall be documented in the client record; and (C) physical restraint and may be subject to injury: a facility employee shall remain present with the client continuously. (12) The use of a restrictive intervention shall be discontinued immediately at any indication of risk to the client's health or safety or immediately after the client gains behavioral control. If the client is unable to gain behavioral control within the time frame specified in the authorization of the intervention, a new authorization must be obtained. (13) The written approval of the designee of the governing body shall be required when the original order for a

[continuation] 1E. The provider has a system to protect and review the rights of individuals for service improvement.	restrictive intervention is renewed for up to a total of 24 hours in accordance with the limits specified in Item (E) of Subparagraph (e)(10) of this Rule. (14) Standing orders or PRN orders shall not be used to authorize the use of seclusion, physical restraint or isolation timeout. (15) The use of a restrictive intervention shall be considered a restriction of the client's rights as specified in G.S. 122C-62(b) or (d). The documentation requirements in this Rule shall satisfy the requirements specified in G.S. 122C-62(e) for rights restrictions. (16) When any restrictive intervention is utilized for a client, notification of others shall occur as follows: (A) those to be notified as soon as possible but within 24 hours of the next working day, to include: (i) the treatment or habilitation team, or its designee, after each use of the intervention; and (ii) a designee of the governing body; and (B) the legally responsible person of a minor client or an incompetent adult client shall be notified immediately unless she/he has requested not to be notified. (17) The facility shall conduct reviews and reports on any and all use of restrictive interventions, including: (A) a regular review by a designee of the governing body, and review by the Client Rights Committee, in compliance with confidentiality rules as specified in 10A NCAC 28A; (B) an investigation of any unusual or possibly unwarranted patterns of utilization; and (C) documentation of the following shall be maintained on a log: (i) name of the client; (ii) name of the responsible professional; (iii) date of each intervention; (iv) time of each intervention; (v) type of intervention; (vi) duration of each intervention; (vii) reason for use of the intervention; (viii) positive and less restrictive alternatives that were used or that were considered but not used and why those alternatives were not used; (ix) debriefing and planning conducted with the client, legally responsible person, if applicable, and staff, as specified in Parts (e)(9)(F) and (G) of this Rule, to eliminate or reduce the probability of the future use of restrictive interventions; and (x) negative effects of the restrictive intervention, if any, on the physical and psychological well-being of the client. (18) The facility shall collect and analyze data on the use of seclusion and physical restraint. The data collected and analyzed shall reflect for each incident: (A) the type of procedure used and the length of time employed; (B) alternatives considered or employed; and (C) the effectiveness of the procedure or alternative employed. The facility shall analyze the data on at least a quarterly basis to monitor effectiveness, determine trends and take corrective action where necessary. The facility shall make the data available to the Secretary upon request. (19) Nothing in this Rule shall be interpreted to prohibit the use of voluntary restrictive interventions at the client's request; however, the procedures in this Rule shall apply with the exception of Subparagraph (f)(3) of this Rule. (f) The restrictive intervention shall be considered a planned intervention and shall be included in the client's treatment/habilitation plan whenever it is used: (1) more than four times, or for more than 40 hours, in a calendar month; (2) in a single episode in which the original order is renewed for up to a total of 24 hours in accordance with the limit specified in Item (E) of Subparagraph (e)(10) of this Rule; or (3) as a measure of therapeutic treatment designed to reduce dangerous, aggressive, self-injurious or undesirable behaviors to a level which will allow the use of less restrictive treatment or habilitation procedures. (g) When a restrictive intervention is used as a planned intervention, facility policy shall specify: (1) the requirement that a consent or approval shall be considered valid for no more than six months and that the decision to continue the specific intervention shall be based on clear and recent behavioral evidence that the intervention is having a positive impact and continues to be needed; (2) prior to the initiation or continued use of any planned intervention, the following written notifications, consents and approvals shall be obtained and documented in the client record: (A) approval of the plan by the responsible professional and the treatment and habilitation team, if

[continuation] 1E. The provider has a system to protect and review the rights of individuals for service improvement.	applicable, shall be based on an assessment of the client and a review of the documentation required by Subparagraph (e)(9) and (e)(14) of this Rule if applicable; (B) consent of the client or legally responsible person, after participation in treatment planning and after the specific intervention and the reason for it have been explained in accordance with 10A NCAC 27D .0201; (C) notification of an advocate/client rights representative that the specific intervention has been planned for the client and the rationale for utilization of the intervention; and (D) physician approval, after an initial medical examination, when the plan includes a specific intervention with reasonably foreseeable physical consequences. In such cases, periodic planned monitoring by a physician shall be incorporated into the plan. (3) within 30 days of initiation of the use of a planned intervention, the Intervention Advisory Committee established in accordance with Rule .0106 of this Section, by majority vote, may recommend approval or disapproval of the plan or may abstain from making a recommendation; (4) within any time during the use of a planned intervention, if requested, the Intervention Advisory Committee shall be given the opportunity to review the treatment/habilitation plan; (5) if any of the persons or committees specified in Subparagraphs (h)(2) or (h)(3) of this Rule do not approve the initial use or continued use of a planned intervention, the intervention shall not be initiated or continued. Appeals regarding the resolution of any disagreement over the use of the planned intervention shall be handled in accordance with governing body policy; and (6) documentation in the client record regarding the use of a planned intervention shall indicate: (A) description and frequency of debriefing with the client, legally responsible person, if applicable, and staff if determined to be clinically necessary. Debriefing shall be conducted as to the level of cognitive functioning of the client; (B) bi-monthly evaluation of the planned by the responsible professional who approved the planned intervention; and (C) review, at least monthly, by the treatment/habilitation team that approved the planned intervention. 10A NCAC 27E .0105 PROTECTIVE DEVICES (a) Whenever a protective device is utilized for a client, the governing body shall develop and implement policy to ensure that: (1) the necessity for the protective device has been assessed and the device is applied by a facility employee who has been trained and has demonstrated competence in the utilization of protective devices; (2) the use of positive and less restrictive alternatives have been reviewed and documented and the protective device selected is the appropriate measure; (3) the client is frequently observed and provided opportunities for toileting, exercise, etc. as needed. When a protective device limits the client's freedom of movement, the client shall be observed at least every hour. Whenever the client is restrained and subject to injury by another client, a facility employee shall remain present with the client continuously. Observations and interventions shall be documented in the client record; (4) protective devices are cleaned at regular intervals; and (5) for facilities operated by or under contract with an area program, the utilization of protective devices in the treatment/habilitation plan shall be subject to review by the Client Rights Committee, as required in 10A NCAC 27G .0504. Copies of this Rule and other pertinent rules are published as Division publication RULES FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES, APSM 30-1,and may be purchased at a cost of five dollars and seventy-five cents ($5.75) per copy. (b) The use of any protective device for the purpose or with the intent of controlling unacceptable behavior shall comply with the requirements of Rule .0104 of this Section. 10A NCAC 27E .0106 INTERVENTION ADVISORY COMMITTEES (a) An Intervention Advisory Committee shall be established to provide additional safeguards in a facility that utilizes restrictive interventions as planned interventions as specified in Rule .0104(g) of this Section. (b) The membership of the Intervention Advisory Committee shall include at least one person who is or has been a consumer of direct services provided by the governing body or who is a close relative of a consumer and: (1) for a facility operated by an area program, the Intervention Advisory Committee shall be the Client Rights Committee or a subcommittee of it, which may include other members; (2) for a facility that is not operated by an area program, but for which a voluntary client rights or human rights committee has been appointed by the governing body, the Intervention Advisory Committee shall be that committee or a subcommittee of it, which may include other members; or

[continuation] 1E. The provider has a system to protect and review the rights of individuals for service improvement.	(3) for a facility that does not meet the conditions of Subparagraph (b)(1) or (2), the committee shall include at least three citizens who are not employees of, or members of the governing body. (c) The Intervention Advisory Committee specified in Subparagraphs (b)(2) or (3) shall have a member or a regular independent consultant who is a professional with training and expertise in the use of the type of interventions being utilized, and who is not directly involved in the treatment or habilitation of the client. (d) The Intervention Advisory Committee shall: (1) have policy that governs its operation and requirements that: (A) access to client information shall be given only when necessary for committee members to perform their duties; (B) committee members shall have access to client records on a need to know basis only upon the written consent of the client or his legally responsible person as specified in G.S. 122C-53(a); and (C) information in the client record shall be treated as confidential information in accordance with G.S. 122C-52 through 122C-56; (2) receive specific training and orientation as to the charge of the committee; (3) be provided with copies of appropriate statutes and rules governing client rights and related issues; (4) be provided, when available, with copies of literature about the use of a proposed intervention and any alternatives; (5) maintain minutes of each meeting; and (6) make an annual written report to the governing body on the activities of the committee. <u>10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS</u> (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of

[continuation] 1E. The provider has a system to protect and review the rights of individuals for service improvement.	MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. <u>10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT</u> (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time.

[continuation] 1E. The provider has a system to protect and review the rights of individuals for service improvement.	(i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. 10A NCAC 27E .0201 SAFEGUARDS REGARDING MEDICATIONS (a) The use of experimental drugs or medication shall be considered research and shall be governed by G.S. 122C-57(f), applicable federal law, licensure requirements codified in 10A NCAC 27G .0209, or any other applicable licensure requirements not inconsistent with state or federal law. (b) The use of other drugs or medications as a treatment measure shall be governed by G.S. 122C-57, and G.S. 90, Articles 1, 4A and 9A. **SPECIFIC RULES FOR 24-HOUR FACILITIES:** 10A NCAC 27F .0101 SCOPE Article 3, Chapter 122C of the General Statutes provides specific rights for each client who receives a mental health, developmental disability, or substance abuse service. This Subchapter delineates the rules regarding those rights that apply in a 24-hour facility. 10A NCAC 27F .0102 LIVING ENVIRONMENT (a) Each client shall be provided: (1) an atmosphere conducive to uninterrupted sleep during scheduled sleeping hours, consistent with the types of services being provided and the type of clients being served; and (2) accessible areas for personal privacy, for at least limited periods of time, unless determined inappropriate by the treatment or habilitation team. (b) Each client shall be free to suitably decorate his room, or his portion of a multi-resident room, with respect to choice, normalization principles, and with respect for the physical structure. Any restrictions on this freedom shall be carried out in

[continuation] 1E. The provider has a system to protect and review the rights of individuals for service improvement.	accordance with governing body policy. 10A NCAC 27F .0103 HEALTH, HYGIENE AND GROOMING (a) Each client shall be assured the right to dignity, privacy and humane care in the provision of personal health, hygiene and grooming care. Such rights shall include, but need not be limited to the: (1) opportunity for a shower or tub bath daily, or more often as needed; (2) opportunity to shave at least daily; (3) opportunity to obtain the services of a barber or a beautician; and (4) provision of linens and towels, toilet paper and soap for each client and other individual personal hygiene articles for each indigent client. Such other articles include but are not limited to toothpaste, toothbrush, sanitary napkins, tampons, shaving cream and shaving utensil. (b) Bathtubs or showers and toilets which ensure individual privacy shall be available. (c) Adequate toilets, lavatory and bath facilities equipped for use by a client with a mobility impairment shall be available. 10A NCAC 27F .0104 STORAGE AND PROTECTION OF CLOTHING AND POSSESSIONS Facility employees shall make every effort to protect each client's personal clothing and possessions from theft, damage, destruction, loss, and misplacement. This includes, but is not limited to, assisting the client in developing and maintaining an inventory of clothing and personal possessions if the client or legally responsible person desires. 10A NCAC 27F .0105 CLIENT'S PERSONAL FUNDS (a) This Rule applies to any 24-hour facility which typically provides residential services to individual clients for more than 30 days. (b) Each competent adult client and each minor above the age of 16 shall be assisted and encouraged to maintain or invest his money in a personal fund account other than at the facility. This shall include, but need not be limited to, investment of funds in interest-bearing accounts. (c) If funds are managed for a client by a facility employee, management of the funds shall occur in accordance with policy and procedures that: (1) assure to the client the right to deposit and withdraw money; (2) regulate the receipt and distribution of funds in a personal fund account; (3) provide for the receipt of deposits made by friends, relatives or others; (4) provide for the keeping of adequate financial records on all transactions affecting funds on deposit in personal fund account; (5) assure that a client's personal funds will be kept separate from any operating funds of the facility; (6) provide for the deduction from a personal fund account payment for treatment or habilitation services when authorized by the client or legally responsible person upon or subsequent to admission of the client; (7) provide for the issuance of receipts to persons depositing or withdrawing funds; and (8) provide the client with a quarterly accounting of his personal fund account. (d) Authorization by the client or legally responsible person is required before a deduction can be made from a personal fund account for any amount owed or alleged to be owed for damages done or alleged to have been done by the client: (1) to the facility; (2) an employee of the facility; (3) to a visitor of the facility; or (4) to another client of the facility. 10A NCAC 27G .0504 CLIENT RIGHTS COMMITTEE (a) The area board shall bear ultimate responsibility for the assurance of client rights. (b) Each area board shall establish at least one Client Rights Committee, and may require that the governing body of a contract agency also establish a Client Rights Committee. The area board shall also develop and implement policy which delineates: (1) composition, size, and method of appointment of committee membership; (2) training and orientation of committee members; (3) frequency of meetings, which shall be at least quarterly; (4) rules of conduct for meetings and voting procedures to be followed; (5) procedures for monitoring the effectiveness of existing and proposed methods and procedures for protecting client rights; (6) requirements for routine reports to the area board regarding seclusion, restraint and isolation time out; and

[continuation] 1E. The provider has a system to protect and review the rights of individuals for service improvement.	(7) other operating procedures. (c) The area-board-established Client Rights Committee shall oversee, for area-operated services and area-contracted services, implementation of the following client rights protections: (1) compliance with G.S. 122C, Article 3; (2) compliance with the provisions of 10A NCAC 27C, 27D, 27E, and 27F governing the protection of client rights, and 10A NCAC 26B governing confidentiality; (2) establishment of a review procedure for any of the following which may be brought by a client, client advocate, parent, legally responsible person, staff or others: (A) client grievances; (B) alleged violations of the rights of individuals or groups, including cases of alleged abuse, neglect or exploitation; (C) concerns regarding the use of restrictive procedures; or (D) failure to provide needed services that are available in the area program. (d) Nothing herein stated shall be interpreted to preclude or usurp the authority of a county Department of Social Services to conduct an investigation of abuse, neglect, or exploitation or the authority of the Governor's Advocacy Council for Persons with Disabilities to conduct investigations regarding alleged violations of client rights. (e) If the area board requires a contract agency to establish a Client Rights Committee, that Committee shall carry out the provisions of this Rule for the contract agency. (f) Each Client Rights Committee shall be composed of a majority of non-area board members, with a reasonable effort made to have all applicable disabilities represented, with consumer and family member representation. Staff who serve on the committee shall not be voting members. (g) The Client Rights Committee shall maintain minutes of its meetings and shall file at least an annual report of its activities with the area board. Clients shall not be identified by name in minutes or in written or oral reports. (h) The area board Client Rights Committee shall review grievances regarding incidents which occur within a contract agency after the governing body of the agency has reviewed the incident and has had opportunity to take action. Incidents of actual or alleged Client Rights violations, the facts of the incident, and the action, if any, made by the contract agency shall be reported to the area director within 30 days of the initial report of the incident, and to the area board within 90 days of the initial report of the incident.

[End of Worksheet 1]

KEY ELEMENTS	CITATIONS
2A. The provider reports incidents according to DMH/DD/SAS requirements [categorization]	10A NCAC 27G .0601: SCOPE OF LOCAL MANAGEMENT ENTITY MONITORING OF FACILITIES AND SERVICES: [See citation in Key Element 1D in Worksheet 1 above.] 10A NCAC 27G .0602 DEFINITIONS [See citation in Key Element 1D in Worksheet 1 above.] 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS [See citation in Key Element 1D in Worksheet 1 above.] 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS [See citation in Key Element 1D in Worksheet 1 above.] 10A NCAC 27G .0606 REFERRAL OF COMPLAINTS TO LOCAL MANAGEMENT ENTITIES PERTAINING TO CATEGORY A OR CATEGORY B PROVIDERS [See citation in Key Element 1D in Worksheet 1 above.] 10A NCAC 27G .0609: LOCAL MANAGEMENT ENTITY REPORTING REQUIREMENTS: [See citation in Key Element 1A in Worksheet 1 above.] SECTION .7000 – LOCAL MANAGEMENT ENTITY RESPONSE TO COMPLAINTS 10A NCAC 27G .7001 SCOPE [See citation in Key Element 1D in Worksheet 1 above.] 10A NCAC 27G .7002 LOCAL MANAGEMENT ENTITY REQUIREMENTS CONCERNING COMPLAINTS [See citation in Key Element 1D in Worksheet 1 above.] 10A NCAC 27G .7003 REQUIREMENTS FOR LOCAL MANAGEMENT ENTITY COMPLAINT INVESTIGATIONS [See citation in Key Element 1D in Worksheet 1 above.] LME QUARTERLY INCIDENT REPORT MEMO/ INSTRUCTIONS: JANUARY, 2006: Purpose: 10A NCAC 27G.0600 requires Local Management Entities (LMEs) to review all Level II and III and selected Level I Incident Reports submitted to them by service providers in their catchment areas and to provide a quarterly report to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The report shall include the following elements: (1) summary of incident data for the quarter, (2) an analysis of trends and patterns, (3) strategies developed to address identified problems or opportunities for improvement, (4) actions taken to implement strategies and make improvements, (5) an evaluation of the results of actions taken, and (6) the next steps being planned to ensure that improvements are sustained or to achieve the desired results if initial actions taken were unsuccessful. The quarterly report shall be submitted using a form provided by the Secretary of the NC DHHS and shall allow LMEs, consumers, the public, and the Division to assess trends and patterns of incidents and to see how this information is being used to support efforts to improve the quality of care delivered. The LME Quarterly Incidents Report (Form QM13) is the designated form for submitting this report. A copy of this form may be found on the Division's website (http://www.dhhs.state.nc.us/mhddsas/manuals/index.htm). What to Report: The local host LME shall provide all of the information requested on the Form QM13. Include all Level 2 and 3 incidents and selected Level 1 incidents reported during the quarter in the host LME's catchment area, regardless of whether this

[continuation] 2A. The provider reports incidents according to DMH/DD/SAS requirements [categorization]	information was previously reported to the State immediately following the occurrence of the incident. To avoid duplication in counts across the state, do not include incidents that occur outside of the LME's catchment area that are reported to the LME as the home LME. The information requested on the form is divided into three sections: Section 1 - Summary of Level 2 and 3 Incidents. This section is divided into three subsections. Subsection 1A - Summary of Level 2 and 3 Incidents (Total Number and Location). In this subsection, report the "Total Number of Incident Reports Received for the Quarter" for each level of incident. This number should be the total unduplicated count of incident reports received for the quarter. Count each incident report only once regardless of the number of separate types of incidents that may have been reported on an individual incident report form. In this subsection, also report the "Number of Reports by Location of Incident". List only one location for each incident report received. The sum of the reports by location should equal the "Total Number of Incident Reports Received for the Quarter". Subsection 1B - Summary of Level 2 and 3 Incidents (By Type of Incident). In this subsection, provide the numbers of incidents reported to the host LME for each of the various types of incidents, including consumer deaths (by cause of death); restrictive interventions; consumer injuries (by cause of injury); allegations of abuse, neglect, and exploitation; medication errors; consumer behavior related incidents, and other reportable incidents. It is possible that one incident report may contain more than one type of incident. Unless otherwise instructed on the incident report (some categories of incident allow only one type of incident to be reported on the incident report), include each type of incident listed on the individual incident report in the appropriate table in this subsection. [For example, suppose a single incident report describes an event in which an aggressive/destructive consumer behavior resulted in a restrictive intervention. In this case, a total of two incidents would be reported in this subsection. One incident would be reported as an "Aggressive /Destructive Act" in the "Consumer Behavior" table, and one incident would be reported in the appropriate row describing the type of restrictive intervention that was applied in the "Restrictive Interventions" table.] [In a second example, suppose an individual incident report was submitted to document that a consumer was administered the wrong medication at the wrong time. In this case, the incident report instructions allow only one type of medication error to be listed for each incident report. Therefore, the incident would be reported in only one place in the "Medication Errors" table, most likely as a "Wrong Medication Administered".] Subsection 1C - Numbers of Providers Reporting Level 2 and 3 Incidents. In this subsection, report the total number of providers submitting incident reports for each level of incident and the highest number of reports for a single provider. For corporate providers with multiple facilities/sites, the count of providers shall be based on individual facilities/sites, not corporate offices. Each individual facility/site will count as a provider. There may be duplication in providers between the first two columns ("Providers with any Level 2 Incidents" and "Providers with any Level 3 Incidents"). The third column ("All Providers with Level 2 and/or 3 Unduplicated") should be an unduplicated count of providers that submitted a Level 2 or 3 incident report during the quarter. [For example, suppose that 10 providers submitted a Level 2 incident report and 2 providers submitted a Level 3 incident report. The number of providers in the Level 2 column would be 10 and the number of providers in the Level 3 column would be 2. Now suppose that one of the providers that submitted a Level 3 incident report also submitted a Level 2 report during the quarter. The total in the "All Providers with Level 2 and/or 3 (Unduplicated)" column would be 11.] The "Highest Number of Reports for a Single Provider" is the number of incident reports submitted by the single provider with the most reports during the quarter. This number indicates how widespread or concentrated incident reporting by providers is for the quarter. Separate columns are provided in Subsections 1A and 1B to report the "Numbers By Level of Incident" (e.g. "Level 2", "Level 3", and "Total"), the "Unduplicated Count of Consumers", and "Highest Number of Reports For a Single Consumer" for each type of incident. The "Numbers By Level of Incident" should be self-explanatory. Simply report the numbers of "Level 2" and "Level 3" incidents for each type of incident. The "Total" is the sum of the two columns. The "Unduplicated Count of Consumers" allows LMEs to identify the number of consumers that generated the incidents being reported. This is useful in showing how widespread or concentrated the incidents are among consumers. [For example, suppose that 10 Level 2 consumer injuries (due to trip or fall) were reported. In addition, suppose that one consumer accounted for 6 of these injuries and four consumers accounted for one each. The "Unduplicated Count of Consumers" in this case would be 5.] The "Highest Number of Reports For a Single Consumer" allows LMEs to identify situations in which a large number of incidents may be due to an individual consumer. [In the above example, the highest number of reports for a single consumer would be 6.] Section 2 - Summary of Selected Level 1 Incidents. In this section, report the aggregate numbers of Level 1 restrictive interventions, medication errors, and searches/seizures reported to the LME by service providers in their quarterly summary reports. Each table in this section includes columns for reporting the number of incident reports, the number of providers

[continuation] 2A. The provider reports incidents according to DMH/DD/SAS requirements [categorization]	reporting, and the highest number of incidents for one consumer. n the "Number of Incident Reports" column, provide the sum of the number of incident reports that service providers reported completing during the quarter for the type of incident indicated. In the "Number of Providers Reporting" column, report the number of service providers that submitted a Provider Quarterly Incident Report (Form QM11) that quarter for the type of incident indicated. In the "Highest Number of Incidents for One Consumer" column, enter the highest number of incidents for the individual consumer with the most incidents of the type indicated reported by an individual service provider. Keep in mind that because service providers are only required to report aggregate information for Level 1 incidents, this number will not reflect all incidents for consumers who were served by more than one service provider during the quarter. Section 3 - How the LME is Analyzing Trends and Using Incident Report Data. This section provides a forum for the LME to share how it is using incident report data to improve the quality of services to consumers. In the space provided, include a brief description of patterns or trends that may have been noted in the analyses of incidents that were reported during the quarter. Describe strategies developed to address identified problems or opportunities for improvement, actions taken to implement strategies and to make needed improvements, an evaluation of the results of actions taken, and next steps being planned to ensure that improvements are sustained or to achieve the desired results if initial actions taken were unsuccessful. In order to meet the current fiscal year Performance Contract performance standard for incident reporting (1.6.3.), the report will need to show clear evidence of an effective process that contains the first four of the above underlined elements. To meet the best practice performance standard, the report will need to show clear evidence of an effective process that contains all five of the above underlined elements. o Examples of analyses the LME may want to consider performing include looking at trends and patterns of incidents from a variety of perspectives including from the service provider's perspective, from the consumer's perspective, from the clinical perspective, and/or from the service system's perspective. From the service provider's perspective, analyses might look at incidents and incident reporting compliance over time, differences in incidents among residential versus non-residential providers, patterns of incidents by type of service provider, comparisons between licensed and unlicensed providers, profiles of particular providers, and how providers are using incident reports information to improve the quality of services and to prevent or reduce the numbers of future incidents. From the consumer's perspective, analyses might look at consumers with high numbers of incidents or comparisons of incidents and responses to incidents between consumers in different age disability groups or diagnostic groups or service settings to understand causes and to develop strategies to prevent or reduce the occurrence of future incidents. From the clinical perspective, analyses might look at clinical issues that might contribute to the occurrence of incidents and focus on developing appropriate interventions that could be used to better manage, to reduce, or to prevent the occurrence of future incidents. From the service system's perspective, analyses might look for issues that appear to be affecting a number of service providers, or a number of consumers across the LME's service system, or that might be associated with the delivery of particular kinds of services or supports in order to develop strategies to improve services and supports and the service delivery system. Examples of actions taken might include steps being taken by the LME to make sure that providers are aware of incident reporting requirements and are appropriately reporting incidents; monitoring of particular providers based on collected information; educating providers about best practices, clinical approaches to preventing or reducing incidents, how to work with consumers to address problems identified through the incident information, and how to develop intervention strategies to better manage and/or to reduce the occurrence of various types of incidents; and working with provider and consumer groups and other LMEs to address systems issues. How To Check the Integrity of the Report: Before submitting the quarterly report, check the integrity of the data reported to ensure that it is correct and is internally consistent. As a check of the integrity of the numbers reported in Section 1A, make sure that the sum of the "Number of Reports by Location of Incident" for each level of incident equals the "Total Number of Incident Reports Received for the Quarter". As a check of the integrity of the numbers reported in Section 1B, make sure that the sum of the numbers for the various categories of incidents for each level of incident equals or exceeds the "Total Number of Incident Reports Received for the Quarter" reported in Section 1A. In cases when all incident reports received identify only one category of incident per incident report, the sum of the incidents in the various categories in Section 1B should equal the total number in Section 1A. In cases when one or more of the incident reports received identify more than one category of incident per incident report, the sum of the various categories of incidents in Section 1B on the quarterly report will exceed the total number in Section 1A. [To provide an example of the second situation, suppose a single incident report is received for an incident in which an aggressive/destructive act by a consumer resulted in a restrictive intervention. In this case, the incident report should identify two categories of incidents (one under consumer behavior and one under restrictive interventions) while the "Total Number of Incident Reports Received for the Quarter" in Section 1A at the top of the report form will show one incident report. This will cause the sum of the various categories of incidents in Section 1B to exceed the total number at the top of the report form in Section 1A.] As a check of the integrity of the numbers reported in Section 1C, make sure that the numbers of providers submitting reports and the highest number of reports for a single provider are internally consistent with the total number of incidents reported in Sections 1A

and 1B. [For example, it would not be internally consistent for Section 1A to report that 10 incident reports were received and for Section 1C to report that 15 providers submitted reports with the highest number of reports for a single provider being 5.]

When to Submit the Report: All incident reports must be individually reviewed and appropriately handled when they are received. Aggregate incident data must be reviewed and analyzed every three months, and a quarterly report submitted to the Division within 20 days after the end of the quarter. The following table describes the months covered and the due dates for submitting the reports.

Report	Months Covered	Due Date
First Quarter	July, August, and September	October 20
Second Quarter	October, November, and December	January 20
Third Quarter	January, February, and March	April 20
Fourth Quarter	April, May, and June	July 20

INCIDENT REPORT CHANGES MEMO: FEBRUARY, 2006:

Incident Reporting Changes for DHHS Incident and Death Report (Form QM02) : The DHHS Incident and Death Report (Form QM02) is being modified, and the revised edition will be made available with the implementation of the web-based incident reporting system. In the meantime, the following reporting changes are to be made effective immediately.

[continuation]

2A.

The provider reports incidents according to DMH/DD/SAS requirements [categorization]

1. Page 1 of 6, Consumer Information, Social Security Number: Do not submit the consumer's social security number. Instead, write the consumer's client number in the space allotted for the social security number. The client number is the identification number assigned to the consumer by the home LME. This is the identification number used to report data to the Division's Consumer Data Warehouse (CDW). It may be up to 15 digits long. The length of the assigned numbers may vary from LME to LME. The LME will provide the client number to the provider as needed.
2. Page 1 of 6, Description of Incident, Other People Involved: Do not provide the name of other consumers in this section. In the check boxes write in the number of other consumers who were involved in the incident. NOTE: When submitting a description of the incident or submitting a statement by a witness, do not include another consumer's name, initials, identification number or any other identifying information.
3. Page 2 of 6, Type of Incident, Other Incident: Unplanned consumer absence more than three hours over time allowed. This refers to more than three hours over the time noted in the Person Centered Plan.
4. Page 5 of 6, DHHS Criteria for Determining Level of Response to Incidents, Consumer Injury: The criteria for reporting an injury to a consumer due to aggressive behavior shall include injuries due to rape or sexual assault. Report as a Level III incident "any injury that results in permanent physical or psychological impairment and any allegation of rape or sexual assault by someone other than a staff member or caregiver."
5. Page 5 of 6, DHHS Criteria for Determining Level of Response to Incidents, Abuse: The criteria for reporting abuse of a consumer shall include rape or sexual assault by a staff member or caregiver. Report as a Level III incident "Any allegation of abuse, neglect, or exploitation that involves an allegation of rape or sexual assault by a staff member or caregiver or results in permanent physical or psychological impairment or arrest."

AGREEMENT BETWEEN LME AND DIRECT-ENROLLED PROVIDERS OF ENHANCED MH/DD/SA SERVICES FOR MEDICAID – UPDATED 5/15/06:

2.6 Incident Reporting: Provider shall report and respond to all client incidents as required under State and Federal law, rules and regulations. Incidents shall be reported in the manner prescribed and on a form provided by the Secretary of DHHS. (See Operations Manual)

CONTRACT BETWEEN LME AND PROVIDER AGENCY FOR STATE-FUNDED MH/DD/SA SERVICES – 6/13/07:

2.7 Incident Reporting: Provider shall report and respond to all client incidents as required under State and Federal law, rules and regulations. Incidents shall be reported in the manner prescribed and on a form provided by the Secretary of the DHHS. (See Operations Manual)

[continuation] 2A. The provider reports incidents according to DMH/DD/SAS requirements [categorization	MEMO: CHANGE IN THE DHHS INCIDENT AND DEATH REPORTING PROCESS REGARDING DEATHS DUE TO UNKNOWN CAUSES: SEPTEMBER, 2007: "…Effective October 1, 2007, all MH/DD/SAS consumer deaths from Unknown Causes are to be considered and processed as Level III incidents. These Level II incidents shall be reported to the home and host LME(s) and to the Division's Quality Management Team. Level III deaths from Unknown Causes are not to be reported to the Division of Health Service Regulation (formerly the Division of Facility Services). Any documentation, such as a Medical Examiner's report, autopsy report, death certificate, or police report, that may shed light on the cause or circumstances of a death that comes in after an incident has been reported shall be submitted to the host LME and the Division's Quality management Team upon receipt. If this documentation indicates that the death is not a Level III incident, the provider shall notify the host LME and Division's Quality Management Team through an amended report (DHHS Incident and Death Report, Form QM 02 Effective October, 2004-Rev 03/08/06)…"
2B The provider reports incidents according to DMH/DD/SAS requirements [notification].	10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT, ISOLATION TIME-OUT & PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL: …e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (16) When any restrictive intervention is utilized for a client, notification of others shall occur as follows: (A) those to be notified as soon as possible but within 24 hours of the next working day, to include: (i) the treatment or habilitation team, or its designee, after each use of the intervention; and (ii) a designee of the governing body; and (B) the legally responsible person of a minor client or an incompetent adult client shall be notified immediately unless she/he has requested not to be notified. (17) The facility shall conduct reviews and reports on any and all use of restrictive interventions, including: (A) a regular review by a designee of the governing body, and review by the Client Rights Committee, in compliance with confidentiality rules as specified in 10A NCAC 28A; (B) an investigation of any unusual or possibly unwarranted patterns of utilization; and (C) documentation of the following shall be maintained on a log: (i) name of the client; (ii) name of the responsible professional; (iii) date of each intervention; (iv) time of each intervention; (v) type of intervention; (vi) duration of each intervention; (vii) reason for use of the intervention; (viii) positive and less restrictive alternatives that were used or that were considered but not used and why those alternatives were not used; (ix) debriefing and planning conducted with the client, legally responsible person, if applicable, and staff, as specified in Parts (e)(9)(F) and (G) of this Rule, to eliminate or reduce the probability of the future use of restrictive interventions; and (x) negative effects of the restrictive intervention, if any, on the physical and psychological well-being of the client. 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS [See citation in Key Element 1D in Worksheet 1 above.] LME QUARTERLY INCIDENTS REPORT MEMO/ INSTRUCTIONS: JANUARY, 2006: [See citation in Key Element 2A in Worksheet 2 above.] INCIDENT REPORT CHANGES MEMO: FEBRUARY, 2006: [See citation in Key Element 2A in Worksheet 1 above.] MEMO: CHANGE IN THE DHHS INCIDENT AND DEATH REPORTING PROCESS REGARDING DEATHS DUE TO UNKNOWN CAUSES: SEPTEMBER, 2007: "…Effective October 1, 2007, all MH/DD/SAS consumer deaths from Unknown Causes are to be considered and processed as Level III incidents. These Level II incidents shall be reported to the home and host LME(s) and to the Division's Quality

[continuation] 2B The provider reports incidents according to DMH/DD/SAS requirements [notification].	Management Team. Level III deaths from Unknown Causes are not to be reported to the Division of Health Service Regulation (formerly the Division of Facility Services). Any documentation, such as a Medical Examiner's report, autopsy report, death certificate, or police report, that may shed light on the cause or circumstances of a death that comes in after an incident has been reported shall be submitted to the host LME and the Division's Quality management Team upon receipt. If this documentation indicates that the death is not a Level III incident, the provider shall notify the host LME and Division's Quality Management Team through an amended report (DHHS Incident and Death Report, Form QM 02 Effective October, 2004-Rev 03/08/06)…" IMPLEMENTATION UPDATE #43: VARIOUS TOPICS: …Incident and Death Reporting: Incidents and deaths must be reported on the Department of Health and Human Service (DHHS) Incident and Death Report Form QM 02 (see below link to access form): Providers of publicly funded services licensed under NC General Statutes 122C, Category A providers (except hospitals), and providers of publicly funded non-licensed periodic or community-based DMH/DD/SAS, Category B providers, must submit the form. Failure to do so, as required by North Carolina Administrative Code 10A NCAC 27G .0600, may result in DHHS taking administrative action against the provider's license or authorization to provide services. This includes CAP-MR/DD, periodic MH/SA and residential providers. All Level II consumer incidents (including deaths from terminal illness/natural cause) must be reported to the host LME. All Level III consumer incidents (including sexual assault and deaths from suicide, accident, homicide/violence and unknown cause) must be reported to the host LME, home LME and the DMH/DD/SAS Quality Management Team. The DHHS incident reporting forms and manual can be accessed at: http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/index.htm. Scroll down to *Incident and Death Response System*. Questions should be directed to the host LME. The MH/DD/SAS Quality Management Team may also be contacted with questions at 919-733-0696 or email questions to contactdmhquality@ncmail.net ...
2C Incident reports submitted by the provider are timely.	10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:

	(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.
[continuation] 2C Incident reports submitted by the provider are timely.	10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident;

[continuation] 2C Incident reports submitted by the provider are timely.	(3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph
2D The provider's response to incidents is appropriate and timely.	10A NCAC 27G .0601: SCOPE OF LOCAL MANAGEMENT ENTITY PROGRAM MONITORING OF FACILITIES AND SERVICES: ISee citation in Key Element 1D in Worksheet 1 above.] 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different;

[continuation] 2D The provider's response to incidents is appropriate and timely.	(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. 10A NCAC 27G .0609: LOCAL MANAGEMENT ENTITY REPORTING REQUIREMENTS: (a) As part of its quality improvement process as set forth in Rule .0201(a)(7) of this Subchapter, the LME shall review, not less than quarterly, patterns and trends in: (1) level I, level II and level III incidents; (2) complaints concerning the provision of public services; and (3) local monitoring results gathered pursuant to requirements established in 10A NCAC 27G .0608. (b) The LME shall provide reports based on the review specified in Paragraph (a) of this Rule. The reports shall be submitted via electronic means to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services quarterly on forms provided by the Secretary. Copies of the reports shall be provided to the LME's area board, local Consumer and Family Advisory Committee, established by G.S. 122C-170, and the local Client Rights Committee, established by Rule .0504 of this

[continuation] 2D The provider's response to incidents is appropriate and timely.	Subchapter. (c) The reports shall include the following: (1) summary numbers of the types of complaints, incidents and results of local monitoring; (2) trends identified through analyses of complaints, incidents and local monitoring; and (3) use of the analyses for improvement of the service system and planning of future monitoring activities. LME QUARTERLY INCIDENTS REPORT MEMO/ INSTRUCTIONS: JANUARY, 2006: [See citation in Key Element 2A in Worksheet 2 above.] INCIDENT REPORT CHANGES MEMO: FEBRUARY, 2006: [See citation in Key Element 2A in Worksheet 1 above.] MEMO: CHANGE IN THE DHHS INCIDENT AND DEATH REPORTING PROCESS REGARDING DEATHS DUE TO UNKNOWN CAUSES: SEPTEMBER, 2007: "…Effective October 1, 2007, all MH/DD/SAS consumer deaths from Unknown Causes are to be considered and processed as Level III incidents. These Level II incidents shall be reported to the home and host LME(s) and to the Division's Quality Management Team. Level III deaths from Unknown Causes are not to be reported to the Division of Health Service Regulation (formerly the Division of Facility Services). Any documentation, such as a Medical Examiner's report, autopsy report, death certificate, or police report that may shed light on the cause or circumstances of a death that comes in after an incident has been reported shall be submitted to the host LME and the Division's Quality management Team upon receipt. If this documentation indicates that the death is not a Level III incident, the provider shall notify the host LME and Division's Quality Management Team through an amended report (DHHS Incident and Death Report, Form QM 02 Effective October, 2004-Rev 03/08/06)…" IMPLEMENTATION UPDATE # 43: VARIOUS TOPICS: …Incident and Death Reporting: Incidents and deaths must be reported on the Department of Health and Human Service (DHHS) Incident and Death Report Form QM 02 (see below link to access form): Providers of publicly funded services licensed under NC General Statutes 122C, Category A providers (except hospitals), and providers of publicly funded non-licensed periodic or community-based DMH/DD/SAS, Category B providers, must submit the form. Failure to do so, as required by North Carolina Administrative Code 10A NCAC 27G .0600, may result in DHHS taking administrative action against the provider's license or authorization to provide services. This includes CAP-MR/DD, periodic MH/SA and residential providers. All Level II consumer incidents (including deaths from terminal illness/natural cause) must be reported to the host LME. All Level III consumer incidents (including sexual assault and deaths from suicide, accident, homicide/violence and unknown cause) must be reported to the host LME, home LME and the DMH/DD/SAS Quality Management Team. The DHHS incident reporting forms and manual can be accessed at: http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/index.htm. Scroll down to *Incident and Death Response System*. Questions should be directed to the host LME. The MH/DD/SAS Quality Management Team may also be contacted with questions at 919-733-0696 or email questions to contactdmhquality@ncmail.net ...
2E The provider's response to complaints is appropriate and timely.	10A NCAC 27G .0601: SCOPE OF LOCAL MANAGEMENT ENTITY PROGRAM MONITORING OF FACILITIES AND SERVICES: [See citation in Key Element 1D in Worksheet 1 above.] 10A NCAC 27G .0606 REFERRAL OF COMPLAINTS TO LOCAL MANAGEMENT ENTITIESS PERTAINING TO CATEGORY A OR CATEGORY B PROVIDERS [See citation in Key Element 1D in Worksheet 1 above.]

[End of Worksheet 2]

KEY ELEMENTS	CITATIONS
3A. Upon hire, staff who will be providing care and treatment have the necessary qualifications and experience to support individuals.	10A NCAC 27G .0104 STAFF DEFINITIONS: The following credentials and qualifications apply to staff described in this Subchapter: (1) "Associate Professional (AP)" within the mental health, developmental disabilities and substance abuse services (mh/dd/sas) system of care means an individual who is a: (a) graduate of a college or university with a masters degree in a human service field with less than one year of full-time, post-graduate degree accumulated mh/dd/sa experience with the population served, or a substance abuse professional with less than one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling. Supervision shall be provided by a qualified professional with the population served until the individual meets one year of experience. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually; or (b) graduate of a college or university with a bachelor's degree in a human service field with less than two years of full-time, post bachelor's degree accumulated mh/dd/sa experience with the population served, or a substance abuse professional with less than two years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling. Supervision shall be provided by a qualified professional with the population served until the individual meets two years of experience. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually; or (c) graduate of a college or university with a bachelor's degree in a field other than human services with less than four years of full-time, post-bachelor's degree accumulated mh/dd/sa experience with the population served, or a substance abuse professional with less than four years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling. Supervision shall be provided by a qualified professional with the population served until the individual meets four years of experience. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually; or (d) registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing with less than four years of full-time accumulated experience in mh/dd/sa with the population served. Supervision shall be provided by a qualified professional with the population served until the individual meets four years of experience. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually…. (15) "Paraprofessional" within the mh/dd/sas system of care means an individual who, with the exception of staff providing respite services or personal care services, has a GED or high school diploma; or no GED or high school diploma, employed prior to November 1, 2001 to provide a mh/dd/sa service. Supervision shall be provided by a qualified professional or associate professional with the population served. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually…. (18) "Qualified professional" means, within the mh/dd/sas system of care: (a) an individual who holds a license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession, except a registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing who also has four years of full-time accumulated experience in mh/dd/sa with the population served; or (b) a graduate of a college or university with a Masters degree in a human service field and has one year of full-time, post-graduate degree accumulated mh/dd/sa experience with the population served, or a substance abuse professional who has one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling; or (c) a graduate of a college or university with a bachelor's degree in a human service field and has two years of full-time, post-bachelor's degree accumulated mh/dd/sa experience with the population served, or a substance abuse professional who has two years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling; or (d) a graduate of a college or university with a bachelor's degree in a field other than human services and has four years of full-time, post-bachelor's degree accumulated mh/dd/sa experience with the population served, or a substance abuse professional who has four years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling. (20) "Qualified substance abuse prevention professional (QSAPP)" means, within the mh/dd/sas system of care:

(a) a graduate of a college or university with a masters degree in a human service field and has one year of full-time, post-graduate degree accumulated supervised experience in substance abuse prevention; or
(b) a graduate of a college or university with a bachelor's degree in a human service field and has two years of full-time, post-bachelor's degree accumulated supervised experience in substance abuse prevention; or
(c) a graduate of a college or university with a bachelor's degree in a field other than human services and has four years of full-time, post bachelor's degree accumulated supervised experience in substance abuse prevention; or
(d) a substance abuse prevention professional who is certified as a Certified Substance Abuse Prevention Consultant (CSAPC) by the North Carolina Substance Abuse Professional Certification Board.

CONTRACT BETWEEN LME AND PROVIDER AGENCY FOR STATE-FUNDED MH/DD/SA SERVICES – 6/13/07:

2.1 Maintenance of Facility Licensure, Accreditation and Credentialing. Provider and its agents providing services on its behalf under this Contract shall obtain and maintain in good standing all applicable accreditation(s), licenses and certificates required by the DHHS policy or law, including but not limited to licensure required by all appropriate agencies and/or Boards. The Provider and its agents providing services on the Provider's behalf under this Contract shall continuously, during the term of this Contract, meet all credentialing and privileging/competency standards as described in this Contract, the Operations Manual or as required by law, policy or regulation.

AGREEMENT BETWEEN LME AND DIRECT-ENROLLED PROVIDERS OF ENHANCED MH/DD/SA SERVICES FOR MEDICAID – UPDATED 5/15/06:

2.1 Maintenance of Facility Licensure, Accreditation and Credentialing. Provider and its agents providing services on its behalf under this Agreement shall obtain and maintain in good standing all applicable accreditation(s), licenses and certificates required by DHHS policy or law, including but not limited to licensure required by all appropriate agencies and/or Boards. The Provider and its agents providing services on the Provider's behalf under this Agreement shall continuously during the term of this Agreement meet all credentialing and privileging/competency standards as described in this Agreement, the Operations Manual or as required by law, policy or regulation.

[continuation]

3A.

Upon hire, staff who will be providing care and treatment have the necessary qualifications and experience to support individuals.

GUIDELINES FOR EVALUATING HUMAN SERVICES DEGREES – PREPARED BY OFFICE OF STATE PERSONNEL: LOCAL GOVERNMENT SERVICES, OCTOBER, 2003:

…HUMAN SERVICES DEGREES: Human Services degrees prepare graduates to provide services to individuals or groups of clients in a variety of settings. Services are to enhance an individual's personal and social well-being, to promote health family and interfamily social development and interactions, to improve the qualify of life for children and their families, and to promote the healthy development and maintenance of groups and the community. Students in these programs receive firsthand skills through practicums. Graduates of human services programs can expect to provide services as advocates for the disadvantaged, providers of preventive health services and providers of physical, emotional, behavioral, social and/or vocational interventions.
The following provides a general outline of some undergraduate and graduate degrees which apply to the human services area. (The attachment of this document outlines more specifically a sample of degrees and coursework from North Carolina colleges/universities). This information should be used as a guide; it is not an exhaustive list of degrees.

1. Commonly accepted degrees which do not require a transcript:
   a. Counseling and Guidance – Graduate programs refine skills in delivering counseling services, administering counseling programs and/or supervising other counselors. The graduate program at UNC-C includes a human services track and a general counseling track, either of which would be acceptable.
   b. Psychology – A psychology undergraduate degree focuses on human development, learning, intelligence, beliefs, assessment and testing, behavior and social influences and attitudes. This degree also prepares one for graduate studies in psychology which include a number of specialties, including general psychology to teach in an academic setting, industrial psychology, experimental/biological, quantitative/cognitive and social psychology.
   c. Rehabilitation Counseling – Graduate programs are designed to prepare one for the professional practice of rehabilitation counseling, with emphasis on theoretical constructs and their application to clinical practice, and to stimulate creative and analytical thought. The courses are specific to rehabilitation counseling, vocational evaluation and career development and placement and are applicable to the human services area.
   d. Social Work – A social work undergraduate degree focuses on the practice of social work, social welfare policies and procedures and human development and the social environment. The graduate degree usually prepares one for specialization in social work such as family-centered practice, child and adolescent practices and public welfare administration.
   e. Special Education – This program trains one to teach special students, usually developments, mentally or

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Upon hire, staff who will be providing care and treatment have the necessary qualifications and experience to support individuals.

emotionally disabled, with most of the curriculum being specific to human services. Coursework ranges from educational psychology to all levels of human growth and development.

f. Therapeutic Recreation – This undergraduate degree prepares students to utilize leisure activities as a form of treatment in working with people who are mentally, physically or emotionally disabled. Courses focus on designing and implementing therapeutic recreation activities for different groups of clients, human physiology and anatomy, the psychology of adjustment and related medical, social and psychology courses.

2. Related degrees with courses which apply to human services but require review of transcript. Reviewer should look for at least 25 semester hours of coursework, which are closely, related to the human services field and specifically to the knowledges, skills and abilities required for the classification. Undergraduate and graduate courses will be considered.

a. Child Development and Family Relations (ECU) – This program emphasizes family and development in all stages of the life cycle, methods and techniques in working with families and administering programs and education for families. The majority of courses at ECU directly apply to the human services field; however, a transcript may be necessary if the degree is from another university to determine the applicability of the courses to the vacant position.

b. Criminal Justice – These undergraduate programs prepare individuals to apply social science concepts and analytical methods to the system of justice and social control and may have several different tracks of study. Those programs which focus on social work or psychology-related coursework may be acceptable as a human service degree; however, those curriculums which emphasize preparation for work in the correctional system, law enforcement and the court system would not be related to the human services field.

c. Education – This degree usually prepares one to teach early childhood education, intermediate or secondary grades although programs may include majors in school administration, reading or special education. General education coursework would not be applicable; however, the graduate and undergraduate degrees in special education usually include coursework relating to learning disabilities, emotionally handicapped or several and profoundly retarded and would be acceptable.

d. Health Education – The undergraduate programs are geared to health education in the school setting; however, some courses may be directly applicable to human services and a transcript is needed. For example, East Carolina University offers a number of related degrees under the Allied Health Services degree, including rehabilitation studies, speech and language and auditory pathology.

e. Nursing – The undergraduate programs prepare one to diagnose and treat "human responses to actual or potential health programs" through the practice of nursing. The major of the courses in the nursing major deal with the sciences, the nursing processes and practice and they include a variety of practicums in clinical settings. A number of courses in these curriculums may be directly applicable to human services; therefore, a transcript should be reviewed before ruling out a candidate. Graduate nursing programs prepare one in specialized areas of nursing, which could also apply directly to the human services field.

f. Occupational Therapy – The undergraduate program prepares one in the professional skills of occupational therapy. The majority of the courses primarily deal with the sciences, but the curriculum also includes courses, which are directly applicable to human services. The graduate programs prepare one in specialized areas of occupational therapy, which are scientific in nature.

g. Physical Therapy – Undergraduate and graduate programs are primarily science courses in orthopedics, evaluation and therapy. Limited courses are available in the human services area; however, courses such as child development are applicable.

h. Religion – Undergraduate programs focus on religious studies such as philosophy, ethics, cultural expression, theology and ideology. A few courses may apply to the human services areas. Graduate programs focus on the history and theology of religions, ethics, culture and specific philosophies, most of which <u>are not applicable to human services</u>. Some seminaries offer a graduate program in Pastoral Care and Counseling with an emphasis on counseling and spiritual growth. The majority of these courses are directly applicable to the human services field with courses in behavioral foundations, personality, group dynamics, development of values, counseling and related practicums.

i. Social Sciences – The curriculum outlines for this area are broader than those in a – h, with courses ranging from human resources, community development and child/family development to substance abuse and intervention and gerontology. The program may prepare one for teaching social sciences in secondary school, for law enforcement or for providing services in social welfare programs, child and family development, gerontology or counseling and guidance. A transcript is necessary to validate the curriculum emphasis.

j. Sociology/Anthropology – The sociology curriculums are very similar to social sciences, preparing students for a "meaningful participation in society" or a liberal arts education. Information on anthropology courses is limited. A few courses may be applicable to the human services field

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Upon hire, staff who will be providing care and treatment have the necessary qualifications and experience to support individuals.

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EQUATING COURSEWORK: Credit is given for coursework successfully completed in an accredited four-year college or university, junior college or community college/technical institute. (In the latter two, the coursework is considered if it applies to the four-year degree). The Educational Directory published by the Department of Health, Education and Welfare is the source document used by the Office of State Personnel for the accredited schools; or a state-accredited school may be accepted.

The normal academic requirement for a college year is 30 semester or 45 quarter hours for undergraduate students and 18-24 semester hours for graduate students. For undergraduates, 27-30 hours is considered a major and 18 semester hours is considered a minor. The normal academic requirement for a four-year degree is 120 semester hours. Graduate programs vary widely and, therefore, the number of hours will depend on the type and length of the program. Generally, 25 to 30 semester hours beyond the undergraduate degree is considered a graduate major. Normally, no credit is allowed for less than ten (10) semester hours or 15 quarter hours.

For degrees which require a transcript (See Items a-j) or for the degree which does not appear to be directly related to human services, the reviewer should be looking for at least 25 semester hours which are closely related to the human services field. Undergraduate and graduate courses can be considered. With four-year degrees, to convert semester hours to quarter hours, divide by two-thirds; to convert quarter hours to semester hours, multiply by two-thirds.

Most internships and practicums are required for the completion of a degree, and are *not* counted as work experience, even though the student may be paid for the work experience. If credit is given, it should be thoroughly documented that the internship is not part of the degree requirement.

The primary role, emphasis of the vacancy and/or special requirements must be reviewed and understood before determining the applicability of courses. The underlying factor in determining the applicability of coursework is whether it is focused on the "helping relationship", understanding and assisting clients/families/groups to meet a range of human needs, understanding and dealing with the needs of special populations, counseling and therapy, human/child development, relationships, behaviors, assessment and evaluation, rehabilitation, etc. If the reviewer cannot determine the applicability of a course, the reviewer should consult with the program manager and/or the classification analyst at the agency level. The classification analysts at the Position Management/Pay Section should be consulted if an applicability question cannot be resolved. If the reviewer is in doubt, a transcript should be requested to insure that an applicant is not screened out.

For additional detail from this guidance document, go to:
http://www.osp.state.nc.us/ExternalHome/Group5/LocalGovmt/HRManual/vi_humansrvcdegrees.pdf

IMPLEMENTATION UPDATE #26 [PARAGRAPH FROM MEMO AND ATTACHMENT]: GUIDANCE ON IMP[LEMENTING CORE RULES:
…Attached is a new document entitled Guidance on Implementing Core Rules that is being provided to assist LMEs and providers in better understanding the complexities of the expectation of Core Rules within the endorsement process.

Guidance on Implementing Core Rules: a. 1. Staffing Requirements for QP and AP: Examine in policy/procedures to determine how provider agency assures its QPs have demonstrated knowledge, skills and abilities required by population served including the validity of college / university degrees. Request transcripts that have an original seal by the issuing college/university. Guides are also available in your local libraries. Check http://www.chea.org/ to see if degree / diploma is from a degree / diploma mill or an accredited school.

10A NCAC 27G .0202 PERSONNEL REQUIREMENTS
(a) All facilities shall have a written job description for the director and each staff position which:
  (1) specifies the minimum level of education, competency, work experience and other qualifications for the position;
  (2) specifies the duties and responsibilities of the position;
  (3) is signed by the staff member and the supervisor; and
  (4) is retained in the staff member's file.
(b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility:
  (1) is at least 18 years of age;
  (2) is able to read, write, understand and follow directions;
  (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position, and
  (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry.
(c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the

[continuation] 3A. Upon hire, staff who will be providing care and treatment have the necessary qualifications and experience to support individuals.	applicant is applying. (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided. (e) A file shall be maintained for each individual employee indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification. (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.

3B The provider demonstrates that background checks and disclosures are conducted in accordance with rule.	§ 122C-80. CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT: [Licensure of Facilities for the Mentally Ill, the Developmentally Disabled, and Substance Abusers]: (a) Definition. – As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. – An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency.* (c) Action. – If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant: (1) The level and seriousness of the crime. (2) The date of the crime. (3) The age of the person at the time of the conviction. (4) The circumstances surrounding the commission of the crime, if known. (5) The nexus between the criminal conduct of the person and the job duties of the position to be filled. (6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed. (7) The subsequent commission by the person of a relevant offense. The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant. (d) Limited Immunity. – A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for: (1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual. (2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section. (e) Relevant Offense. – As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18,

[continuation] 3B The provider demonstrates that background checks and disclosures are conducted in accordance with rule.	Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. (f) Penalty for Furnishing False Information. – Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor. (g) Conditional Employment. – A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met: (1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.) * Note: This means that criminal record checks are required by law only for positions that do not require an occupational license in a facility licensed under Article 2 of 122C-80. This statute does not apply to applicants seeking employment with a service provider agency that is not subject to Article 2 regulations [i.e., periodic]. Those applicants are only required to disclose any criminal conviction to the provider agency. See 10A NCAC 27G .0202 (c) below. 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS... (b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility: (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry. (c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying. (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided. (e) A file shall be maintained for each individual employee indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification.
3C The job description meets the requirements of the position outlined in the service definition.	10A NCAC 27G .0202 PERSONNEL REQUIREMENTS: [See citation in Key Element 3A in Worksheet 3 above.] 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS: [See citation in Key Element 3A in Worksheet 3 above.] 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS: [See citation in Key Element 3A in Worksheet 3 above.] SEE 10A NCAC 27G .0104 STAFF DEFINITIONS - - FOR A LISTING OF OTHER STAFF DEFINITIONS AS APPLICABLE:: http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2027%20-%20mental%20health,%20community%20facilities%20and%20services/subchapter%20g/10a%20ncac%2027g%20.0104.html FOR SERVICE-SPECIFIC RULES, go to http://reports.oah.state.nc.us/ncac.asp?folderName=\Title%2010A%20-20Health%20and%20Human%20Services. SERVICE DEFINITIONS: LINKS TO ACCESS THE SPECIFIC SERVICE DEFINITIONS: DMA CLINICAL COVERAGE POLICIES 8A, 8D-1, AND 8D-2, http://www.ncdhhs.gov/dma/mp/mpindex.htm; JULY, 2005, SPECIAL MEDICAID BULLETIN FOR TARGETED CASE MANAGEMENT, http://www.ncdhhs.gov/dma/bulletin/DDTargetedCaseMgmt.pdf; DMH/DD/SA SERVICE DEFINITIONS OF 1/1/03, found here: http://www.ncdhhs.gov/mhddsas/servicedefinitions/index.htm; IMPLEMENTATION UPDATE #5: DEVELOPMENTAL THERAPY, http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/dmadmh2-23-06update5.pdf.

3D Staff receive ongoing supervision as required.	10A NCAC 27G .0104 STAFF DEFINITIONS:… (1) (a-d) For Associate Professionals: …Supervision shall be provided by a qualified professional with the population served until the individual meets [(a) 1, (b) 2, (c) 4, or (d) 4] year[s] of experience. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually… (15) For Paraprofessionals: Supervision shall be provided by a qualified professional or associate professional with the population served. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually…. IMPLEMENTATION UPDATE #51: CAP-MR/DD UPDATE: …Supervision of Paraprofessionals: The new waivers require the services delivered by paraprofessionals to be performed under the supervision of a Qualified Professional (QP). Associate Professional staff may provide administrative supervision for paraprofessionals – scheduling, leave approval and timekeeping, monitoring compliance with requirements for training, etc. – but the actual services and supports delivered by the paraprofessional must be supervised by the QP. This change went into effect as of November 1, 2008. APPENDIX B OF IMPLEMENTATION UPDATE #36: SERVICE DEFINITION TRAINING REQUIREMENTS: ...MST: …minimum of 1 hour of group supervision and 1 hour of phone consultation per week… SERVICE DEFINITIONS: LINKS TO ACCESS THE SPECIFIC SERVICE DEFINITIONS: DMA CLINICAL COVERAGE POLICIES 8A, 8D-1, AND 8D-2, http://www.ncdhhs.gov/dma/mp/mpindex.htm; JULY, 2005, SPECIAL MEDICAID BULLETIN FOR TARGETED CASE MANAGEMENT, http://www.ncdhhs.gov/dma/bulletin/DDTargetedCaseMgmt.pdf; DMH/DD/SA SERVICE DEFINITIONS OF 1/1/03, found here: http://www.ncdhhs.gov/mhddsas/servicedefinitions/index.htm; IMPLEMENTATION UPDATE #5: DEVELOPMENTAL THERAPY, http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/dmadmh2-23-06update5.pdf.
3E Employees receive required training.	10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: …(3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS: (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.

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Employees receive required training.

10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT:

(a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually.

(b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers_shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated.

(c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions.

(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.

(e) Formal refresher training must be completed by each service provider periodically (minimum annually).

(f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.

(g) Acceptable training programs shall include, but are not limited to, presentation of:

(1) refresher information on alternatives to the use of restrictive interventions;

(2) guidelines on when to intervene (understanding imminent danger to self and others);

(4) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention);

(4) strategies for the safe implementation of restrictive interventions;

(5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention;

(6) prohibited procedures;

(7) debriefing strategies, including their importance and purpose; and

(8) documentation methods/procedures.

(h) Service providers shall maintain documentation of initial and refresher training for at least three years.

(1) Documentation shall include:

(A) who participated in the training and the outcomes (pass/fail);

(B) when and where they attended; and

(C) instructor's name.

(2) The Division of MH/DD/SAS may review/request this documentation at any time.

(i) Instructor Qualification and Training Requirements:

(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.

(2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out.

(3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.

(4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.

(5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule.

(6) Acceptable instructor training programs shall include, but not be limited to, presentation of:

(A) understanding the adult learner;

(B) methods for teaching content of the course;

(C) evaluation of trainee performance; and

(D) documentation procedures.

(7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule.

(8) Trainers shall be currently trained in CPR.

(9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach.

(10) Trainers shall teach a program on the use of restrictive interventions at least once annually.

(11) Trainers shall complete a refresher instructor training at least every two years.

(k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.

(1) Documentation shall include:

(A) who participated in the training and the outcome (pass/fail);
(B) when and where they attended; and
(C) instructor's name.

(2) The Division of MH/DD/SAS may review/request this documentation at any time.

(l) Qualifications of Coaches:

(1) Coaches shall meet all preparation requirements as a trainer.

(2) Coaches shall teach at least three times, the course which is being coached.

(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.

(m) Documentation shall be the same preparation as for trainers.

SERVICE DEFINITIONS: LINKS TO ACCESS THE SPECIFIC SERVICE DEFINITIONS:

DMA CLINICAL COVERAGE POLICIES 8A, 8D-1, AND 8D-2, http://www.ncdhhs.gov/dma/mp/mpindex.htm;

JULY, 2005, SPECIAL MEDICAID BULLETIN FOR TARGETED CASE MANAGEMENT, http://www.ncdhhs.gov/dma/bulletin/DDTargetedCaseMgmt.pdf;

DMH/DD/SA SERVICE DEFINITIONS OF 1/1/03, found here: http://www.ncdhhs.gov/mhddsas/servicedefinitions/index.htm;

IMPLEMENTATION UPDATE #5: DEVELOPMENTAL THERAPY, http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/dmadmh2-23-06update5.pdf.

[continuation]

3E.

Employees receive required training.

IMPLEMENTATION UPDATE #36: TRAINING:

In July 2006, we communicated through Implementation Update # 10 the courses required to satisfy the training requirements for the service definitions. The training requirements for Community Support, Mobile Crisis and Intensive In-Home Services have indicated that the training must be delivered by "DMH/DD/SAS endorsed trainers." Similarly, Assertive Community Treatment Team (ACTT) has required training be received from the Evidenced Based Practices Center of Southeastern AHEC. After careful thought and analysis, we have removed these requirements as well as the requirement for trainers to hold a master's degree or higher in order to provide the training. The specific training requirements for each service definition are outlined in *Appendix B*.

It is our belief that implementing these changes will allow greater flexibility within provider agencies to train staff and build internal capacity, as well as offer better access to trainers. While the requirement to have training delivered by endorsed trainers has been eliminated, the service definition specific training must still be delivered based upon the minimal required training elements approved by our Divisions. DMH/DD/SAS has developed and implemented a clinical skills training web page (www.ncdhhs.gov/mhddsas). On this web page are the required training elements for Community Support, Mobile Crisis and Intensive In-Home Services, along with pre and post tests and evaluation templates. These elements are to be used to develop the full training curricula to meet the hourly requirements for each service definition. Providers may choose to develop their own curriculum to develop internal capacity but the curriculum must be based on the minimal required training elements posted on the web page listed above. The information necessary to offer ACTT training from the SAMHSA ACTT Toolkit and the NAMI PACT Manual also is included on this website.

Additionally, listed on the website is information on the trainers who had previously been endorsed to provide these trainings. We encourage but will not require providers to use formerly endorsed trainers, the Behavioral Healthcare Resource Program at the UNC School of Social Work, the NC Evidence Based Practice Center at Southern Regional AHEC, and other entities with previous experience in training for these services to conduct "train the trainer" classes for any other trainers that the provider may choose use to train their staff in the future.

Provider agencies will continue to have responsibility for maintaining documentation to verify that staff has completed the required training. All staff that provide services must receive required training in accordance with the timeframes outlined in the service definition or within 90 days of employment, which ever occurs first. Individual staff who deliver multiple services only need to take a course that may be required for by multiple service definitions only one time to fulfill the requisites for all definitions. For example, a person who provides both Community Support and Community Support Team need only take one 6 hour Person Centered Thinking course to fulfill the 6 hour requirement for each definition. The service definition specific training must be taken for each service the individual delivers. Training required for other purposes – such as NCI, CPR, first aid – may not be counted toward any of the optional training hours outlined in the attachment. Up to three hours of optional training may be delivered via web-based learning programs if the web-based training includes a post-test to verify understanding of the materials and the program provides documentation of completion. Documentation of completion consists of a certificate of completion indicating the name and date of

[continuation] 3E. Employees receive required training.	the training and name of trainer along with the number of contact hours received. The individual who received the training should have his or her name on the certificate and a copy of the certificate should be retained in the personnel file for inspection during audits. DMH/DD/SAS has developed a dedicated an email address to receive questions regarding training. Please email DMH.training@ncmail.net with all questions regarding service definition training. APPENDIX B OF IMPLEMENTATION UPDATE #36: SERVICE DEFINITION TRAINING REQUIREMENTS: Community Support: 20 hours to include service definition-specific and crisis response training: 6 hours service definition training; 3 hours crisis response; 6 hours Person Centered Thinking; 2-5 hours in other topics related to service and population(s) being served. For QP staff responsible for PCP development: 3 hours on "PCP Instructional Elements." CST: 20 hours to include service definition-specific and crisis management training: 6 hours service definition training; 3 hours crisis response; 6 hours Person Centered Thinking; 2-5 hours in other topics related to service and population(s) being served. For QP staff responsible for PCP development: 3 hours on "PCP Instructional Elements." MCM: 20 hours in appropriate crisis intervention strategies: 6 hours service definition training; 6 hours Person-Centered Thinking, 8 hours in other content areas to achieve 20 hours of intervention strategies. First responder Crisis Toolkit training is highly recommended. Intensive In-Home: 12 hours service definition training; 6 hours Person-Centered Thinking; 3 hours "PCP Instructional Elements;" 2-5 hours in other content areas related to children/adolescents. Crisis response training is highly recommended. ACTT: DMH/DD/SAS approved service definition training; 6 hours Person-Centered Thinking; additional training in other content options is encouraged. For QP staff responsible for PCP development: 3 hours on "PCP Instructional Elements." SAIOP and SACOT: 6 hours Person-Centered Thinking; additional training in other content options congruent with the goals of ASAM is encouraged. For QP staff responsible for PCP development: 3 hours on "PCP Instructional Elements." Diagnostic Assessment: 6 hours of Person-Centered Thinking; 6 hours service definition training is highly recommended. MST: MST introductory and quarterly training,; minimum of 1 hour of group supervision and 1 hour of phone consultation per week; 6 hours of Person-Centered Thinking. For QP staff responsible for PCP development: 3 hours on "PCP Instructional Elements." PSR: 6 hours of Person-Centered Thinking. Child & Adolescent Day Treatment: 6 hours of Person-Centered Thinking, For QP staff responsible for PCP development: 3 hours on "PCP Instructional Elements." Partial Hospitalization: 6 hours of Person-Centered Thinking. Professional Treatment Services in Facility-Based Crisis Programs: 6 hours of Person-Centered Thinking. SA Non-Medical Community Residential Treatment: 6 hours of Person-Centered Thinking. Highly recommended: 6 hours of training covering all substance abuse residential service definitions. SA Medically Monitored Community Residential Treatment: 6 hours of Person-Centered Thinking. Highly recommended: 6 hours of training covering all substance abuse residential service definitions. Medically Supervised or ADATC Detoxification/Crisis Stabilization: 6 hours of Person-Centered Thinking. Highly recommended: 6 hours of training covering all substance abuse residential service definitions. Ambulatory Detoxification: 6 hours of Person-Centered Thinking. Highly recommended: 6 hours of training covering all substance abuse residential service definitions. Social Setting Detoxification: 6 hours of Person-Centered Thinking. Highly recommended: 6 hours of training covering all substance abuse residential service definitions. Non-Hospital Medical Detoxification: 6 hours of Person-Centered Thinking. Highly recommended: 6 hours of training covering all substance abuse residential service definitions. Targeted Case Management: 6 hours of Person-Centered Thinking; 3 hours training on "PCP Instructional Elements." IMPLEMENTATION UPDATE #43: …NCI PROFESSIONAL REQUIREMENTS: Training on Alternatives to Restrictive Interventions and Demonstration of Competency for Licensed Professionals in Community Facilities: North Carolina's legal requirements for restrictive interventions are found at G.S. 122C-60 and in the North Carolina Administrative Code (NCAC). Training on Alternatives to Restrictive Interventions and demonstrated competence in a minimum number of core areas is outlined in 10A NCAC 27E .0107. Training Requirements: The training requirements under these rules state, "Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented." The rules also state that training shall be

	competency-based (per state competencies), approved by DMH/DD/SAS, and formal refresher training must be completed by each service provider at least annually. Competencies: The rule further states, "Staff shall demonstrate competence in the following core areas: 1. knowledge and understanding of the people being served; 2. recognizing and interpreting human behavior; 3. recognizing the effect of internal and external stressors that may affect people with disabilities; 4. strategies for building positive relationships with persons with disabilities; 5. recognizing cultural, environmental and organizational factors that may affect people with disabilities; 6. recognizing the importance of and assisting in the person's involvement in making decisions about their life; 7. skills in assessing individual risk for escalating behavior; 8. communication strategies for defusing and de-escalating potentially dangerous behavior; and 9. positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe)." The rule cited above requires that "staff, including service providers," among others, shall demonstrate competence by successfully completing training…" The NCI training (Parts A, B, and C) is the curriculum used for such training across the state. The minimal requirement is a participant's successful completion of NCI Part A, unless more restrictive interventions are used. Part A covers prevention and alternatives to restraints, seclusion, and isolation time out. Part B covers the use of physical and restrictive interventions. Training in both Part A and Part B is required if an agency will be using physical techniques.
[continuation] 3E. Employees receive required training.	Option for Licensed Professionals: Licensed professionals, by virtue of their extensive training and experience, may elect to either take Part A NCI training, or they may attest to their competence in each of the nine areas outlined above by signing an attestation statement confirming that they have reviewed the nine competencies and that they are proficient and well-skilled in each of these areas. This statement must be submitted to the facility director or CEO for approval and maintained in the licensed professional's personnel file. Option for Service Providers: North Carolina Intervention (NCI) is the standardized training program to prevent the use of restraints and seclusion created and supported by the DMH/DD/SAS. Agencies may choose to use this curriculum. If NCI is chosen, providers must use certified NCI instructors. Agencies may use training programs of their choice, as long as they are approved by the DMH/DD/SAS. The training can be accessed through a network of approved providers across North Carolina found at the following link: http://www.ncdmh.net/NCI-Public/index.htm. Agencies may also develop their own curriculum; the curriculum must be reviewed and approved by the state. The Division Curriculum Review Committee reviews curricula based on training competencies. These competencies describe the abilities the trainee should gain during training. They are divided into three sections: prevention, use, and instructor training… IMPLEMENTATION UPDATE #63: Transition to Psychosocial Rehabilitation Services for Recipients Receiving PSR and Community Support: All Psychosocial Rehabilitation (PSR) service authorizations, for recipients currently receiving PSR and Community Support (CS) services, which are end dated December 31, 2009 or earlier will follow the below process for reauthorization that must occur prior to the date that the current PSR authorization expires.* ▪ The PSR provider must work with the CS provider to obtain the current PCP. ▪ In the event that the PSR provider is unable to obtain the PCP after reasonable efforts, the LME may be contacted to assist in the process. ▪ PSR providers must submit the ITR and a PCP Update/Revision with appropriate signatures to ValueOptions for the reauthorization request. A service order signature (for medical necessity by an MD/DO, PA, APN, PhD psychologist) is only required if a new service is added to the PCP. ▪ The maximum authorization may be up to 180 days. ▪ The PSR qualified professional, in addition to 6 hours of "PCP Thinking," must complete the required 3 hours of "PCP Instructional Elements" training. The PCP Instructional Webcast Training (http://www.ncdhhs.gov/mhddsas/pcp.htm) or other PCP planning/writing training may fulfill this requirement. The qualified professional must be complete this training within sixty (60) days of this IU #63 or within 30 days of hire, whichever comes first.

[continuation] 3E. Employees receive required training.	IMPLEMENTATION UPDATE #65: PCP Development by Therapeutic Foster Care Providers: In response to concerns from Therapeutic Foster Care (TFC) placement agencies regarding difficulties in accessing Community Support services for the timely completion of the Person Centered Plan (PCP) for children and adolescents receiving TFC, the Department of Health and Human Services (DHHS) is announcing the following policy change: In instances where a child does not have Community Support services or another clinical home service, a qualified professional (QP) on staff with the licensed private child-placing agency (LCPA) may complete the PCP as required for submission. The TFC QP, in addition to the six hours of "Person Centered Thinking" must also complete a required three hours of "PCP Instructional Elements" training prior to developing a PCP. See Implementation Update #10 (http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/dmadmh7-6-06update10.pdf) and the updated PCP manual on the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services' (DMH/DD/SAS) website (http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/pcp/pcp_2008_instruction_manual.pdf) for more information. It is noted that there are a wide variety of very good Person Centered Thinking trainings currently available in NC. The PCP Instructional Webcast Training (http://www.ncdhhs.gov/mhddsas/pcp.htm) or other PCP planning/writing training may aid in fulfilling these requirements, as well. This policy change is made possible by a revision to section 10A NCAC 70G .0503 PLACEMENT SERVICES for foster parents and therapeutic foster parents, effective November 1, 2009 that requires supervision of therapeutic foster parents by a qualified professional as defined in 10A NCAC 27G. 0503. Under this requirement, an LCPA will have on staff individuals qualified to assume the responsibility for completing PCPs for children in their care.

[End of Worksheet 3]

KEY ELEMENTS	CITATIONS
4A Information gathered through assessments, person-centered description, and characteristics/ observations/ justifications for goals is incorporated into the PCP.	10A NCAC 27G .0103…: GENERAL DEFINITIONS … (a) This Rule contains definitions that apply to all of the rules in this Subchapter. (b) Unless otherwise indicated, the following terms shall have the meanings specified: (1) "Accreditation" means the authorization granted to an area program by DMH/DD/SAS, as a result of demonstrated compliance with the standards established in these Rules, to provide specified services. (2) "Administering medication" means direct application of a drug to the body of a client by injection, inhalation, ingestion, or any other means. (3) "Adolescent" means a minor from 13 through 17 years of age. (4) "Adult" means a person 18 years of age or older or a person under 18 years of age who has been married or who has been emancipated by a court of competent jurisdiction or is a member of the armed forces. (5) "Alcohol abuse" means psychoactive substance abuse which is a residual category for noting maladaptive patterns of psychoactive substance use that have never met the criteria for dependence for that particular class of substance and which continues despite adverse consequences. The criteria for alcohol abuse delineated in the DSM IV is incorporated by reference. (6) "Alcohol dependence" means psychoactive substance dependence which is a cluster of cognitive behavioral, and physiologic symptoms that indicate that a person has impaired control of psychoactive substance use and continues use of the substance despite adverse consequences. The criteria for alcohol dependence delineated in the DSM IV is incorporated by reference. (7) "Area program" means a legally constituted public agency providing mental health, developmental disabilities and substance abuse services for a catchment area designated by the Commission. For purposes of these Rules, the term "area program" means the same as "area authority" as defined in G.S. 122C-3. (8) "Assessment" means a procedure for determining the nature and extent of the need for which the individual is seeking service. (9) "Child" means a minor from birth through 12 years of age. (10) "Children and adolescents with emotional disturbance" means minors from birth through 17 years of age who have behavioral, mental, or emotional problems which are severe enough to significantly impair their ability to function at home, in school, or in community settings. (11) "Client" means the same as defined in G.S. 122C-3. Unless otherwise specified, when used in the context of consent, consultation, or other function for a minor or for an adult who lacks the capacity to perform the required function, the term "client" shall include the legally responsible person. (12) "Client record" means a documented account of all services provided to a client. (13) "Commission" means the same as defined in G.S. 122C-3. (14) "Contract agency" means a legally constituted entity with which the area program contracts for a service exclusive of intermittent purchase of service for an individually identified client. (15) "Day/night service" means a service provided on a regular basis, in a structured environment that is offered to the same individual for a period of three or more hours within a 24-hour period. (16) "Detoxification" means the physiological withdrawal of an individual from alcohol or other drugs in order that the individual can participate in rehabilitation activities. (17) "DHSR" means the Division of Health Service Regulation, 701 Barbour Drive, Raleigh, N.C. 27603. (18) "Direct care staff" means an individual who provides active direct care, treatment, rehabilitation or habilitation services to clients. (19) "Division Director" means the Director of DMH/DD/SAS. (20) "DMH/DD/SAS" means the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, 3001 Mail Service Center, Raleigh, NC 27699-3001. (21) "Documentation" means provision of written or electronic, dated and authenticated evidence of the delivery of client services or compliance with statutes or rules, e.g., entries in the client record, policies and procedures, minutes of meetings, memoranda, reports, schedules, notices and announcements. (22) "Drug abuse" means psychoactive substance abuse which is a residual category for noting maladaptive patterns of psychoactive substance use that have never met the criteria for dependence for that particular class of substance which continues despite adverse consequences. The criteria for drug abuse delineated in the DSM IV is incorporated by reference.

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4A.

Information gathered through assessments, person-centered description, and characteristics/ observations/ justifications for goals is incorporated into the PCP.

(23) "Drug dependence" means psychoactive substance dependence which is a cluster of cognitive behavioral, and physiologic symptoms that indicate that a person has impaired control of psychoactive substance use and continues use of the substance despite adverse consequences. The criteria for drug dependence delineated in the DSM IV is incorporated by reference.

(24) "DSM IV" means the publication of that title published by the American Psychiatric Association, 1400 K Street, N.W., Washington, D.C. 20005 at a cost of thirty nine dollars and ninety-five cents ($39.95) for the soft cover edition and fifty four dollars and ninety-five cents ($54.95) for the hard cover edition. Where used in these definitions, incorporation by reference of DSM IV includes subsequent amendments and editions of the referenced material.

(25) "DWI" means driving while impaired, as defined in G.S. 20-138.1.

(26) "Evaluation" means an assessment service that provides for an appraisal of a client in order to determine the nature of the client's problem and his need for services. The services may include an assessment of the nature and extent of the client's problem through a systematic appraisal of any combination of mental, psychological, physical, behavioral, functional, social, economic, and intellectual resources, for the purposes of diagnosis and determination of the disability of the client, the client's level of eligibility, and the most appropriate plan, if any, for services.

(27) "Facility" means the same as defined in G.S. 122C-3.

(28) "Foster parent" means an individual who provides substitute care for a planned period for a child when his own family or legal guardian cannot care for him; and who is licensed by the N.C. Department of Health and Human Services and supervised by the County Department of Social Services, or by a private program licensed or approved to engage in child care or child placing activities.

(29) "Governing body" means, in the case of a corporation, the board of directors; in the case of an area authority, the area board; and in all other cases, the owner of the facility.

(30) "Habilitation" means the same as defined in G.S. 122C-3.

(31) "Hearing" means, unless otherwise specified, a contested case hearing under G.S. 150B, Article 3.

(32) "Incident" means any happening which is not consistent with the routine operation of a facility or service or the routine care of a client and that is likely to lead to adverse effects upon a client.

(33) "Infant" means an individual from birth to one year of age.

(34) "Individualized education program" means a written statement for a child with special needs that is developed and implemented pursuant to 16 NCAC 2E .1500 (Rules Governing Programs and Services for Children with Special Needs) available from the Department of Public Instruction.

(35) "Inpatient service" means a service provided in a hospital setting on a 24-hour basis under the direction of a physician. The service provides continuous, close supervision for individuals with moderate to severe mental or substance abuse problems.

(36) "Legend drug" means a drug that cannot be dispensed without a prescription.

(37) "License" means a permit to operate a facility which is issued by DHSR under G.S. 122C, Article 2.

(38) "Medication" means a substance recognized in the official "United States Pharmacopoeia" or "National Formulary" intended for use in the diagnosis, mitigation, treatment or prevention of disease.

(39) "Minor" means a person under 18 years of age who has not been married or who has not been emancipated by a decree issued by a court of competent jurisdiction or is not a member of the armed forces.

(40) "Operator" means the designated agent of the governing body who is responsible for the management of a licensable facility.

(41) "Outpatient service" means the same as periodic service.

(42) "Parent" means the legally responsible person unless otherwise clear from the context.

(43) "Periodic service" means a service provided on an episodic basis, either regularly or intermittently, through short, recurring visits for persons with mental illness, developmental disability or who are substance abusers.

(44) "Preschool age child" means a child from three to five years old.

(45) "Prevailing wage" means the wage rate paid to an experienced worker who is not disabled for the work to be performed.

(46) "Private facility" means a facility not operated by or under contract with an area program.

(47) "Provider" means an individual, agency or organization that provides mental health, developmental disabilities or substance abuse services.

(48) "Rehabilitation" means training, care and specialized therapies undertaken to assist a client to reacquire or maximize any or all lost skills or functional abilities.

(49) "Residential service," unless otherwise provided in these Rules, means a service provided in a 24-hour living environment in a non-hospital setting where room, board, and supervision are an integral part of the care, treatment, habilitation or rehabilitation provided to the individual.

(50) "School aged youth" means individuals from six through twenty-one years of age.

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4A.

Information gathered through assessments, person-centered description, and characteristics/ observations/ justifications for goals is incorporated into the PCP.

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(51) "Screening" means an assessment service that provides for an appraisal of an individual who is not a client in order to determine the nature of the individual's problem and his need for services. The service may include an assessment of the nature and extent of the individual's problem through a systematic appraisal of any combination of mental, psychological, physical, behavioral, functional, social, economic, and intellectual resources, for the purposes of diagnosis and determination of the disability of the individual, level of eligibility, if the individual will become a client, and the most appropriate plan, if any, for services.
(52) "Secretary" means the Secretary of the Department of Health and Human Services or designee.
(53) "Service" means an activity or interaction intended to benefit another, with, or on behalf of, an individual who is in need of assistance, care, habilitation, intervention, rehabilitation or treatment.
(54) "Service plan" means the same as treatment/habilitation plan defined in this Section.
(55) "Staff member" means any individual who is employed by the facility.
(56) "State facility" means the term as defined in G.S. 122C.
(57) "Support services" means services provided to enhance an individual's progress in his primary treatment/habilitation program.
(58) "System of care" means a spectrum of community based mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of emotionally disturbed children and adolescents.
(59) "Toddler" means an individual from one through two years of age.
(60) "Treatment" means the process of providing for the physical, emotional, psychological and social needs of clients through services.
(61) "Treatment/habilitation plan" means a plan in which one or more professionals, privileged in accordance with the governing body's policy, working with the client and family members or other service providers, document which services will be provided and the goals, objectives and strategies that will be implemented to achieve the identified outcomes. A treatment plan may also be called a service plan.
(62) "Twenty-four hour service" means a service which is provided to a client on a 24-hour continuous basis.

10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN

(a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, & shall include, but not be limited to:
  (1) the client's presenting problem;
  (2) the client's needs and strengths;
  (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission;
  (4) a pertinent social, family, and medical history; and
  (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs.
(b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.
(c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.
(d) The plan shall include:
  (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;
  (2) strategies;
  (3) staff responsible;
  (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;
  (5) basis for evaluation or assessment of outcome achievement; and
  (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.

APSM 45-2: RECORDS MANAGEMENT & DOCUMENTATION MANUAL: CHAPTER 5: INITIAL CLINICAL ASSESSMENTS AND EVALUATIONS:

The Comprehensive Clinical Assessment: The completion of a comprehensive clinical assessment [CCA] is required for the development of a Complete PCP. A comprehensive clinical assessment is a clinical evaluation performed by a qualified provider who has the appropriate credentials and meets the requirements identified in the specific assessment used. The purpose of a CCA is to provide the clinical home provider [QP] with the necessary data and recommendations to perform the analysis and synthesis

[continuation] 4A. Information gathered through assessments, person-centered description, and characteristics/ observations/ justifications for goals is incorporated into the PCP.	of this information in the development of the PCP with the individual. A CCA offers an opinion as to whether the individual is appropriate for and can benefit from services. It also evaluates the individual's level of readiness and motivation to engage in treatment, and for individuals with substance abuse conditions, recommends a level of placement using the ASAM Criteria. For consumers with developmental disabilities, the CCA provides a basis for identifying an individual's comprehensive service and support needs and to facilitate the completion of the NC-SNAP. A CCA is not a service definition, but rather a face-to-face evaluation[s] whose purpose is to assess the individual's presenting mental health, developmental disability, and/or substance abuse conditions and symptoms, resulting in the issuance of a written report, and providing the clinical basis for the development of the PCP. In addition, a CCA assists the clinician in gathering the information essential to arriving at a clinical diagnosis and formulating a clinical opinion about a recommended course of action in terms of services, supports, and treatment. The results of a comprehensive clinical assessment also contribute to the establishment of medical necessity. A service order is not needed in order to conduct a CCA…. A CCA may consist of evaluations from multiple sources. There is not a standardized format for the CCA; however, altogether the CCA must include the following elements: ▪ A chronological general health and behavioral health history [including both mental health and substance abuse] of the recipient's symptoms, treatment, treatment response and attitudes about treatment over time, emphasizing factors that have contributed to or inhibited previous recovery efforts; ▪ Biological, psychological, familial, social, developmental, and environmental dimensions and identifies strengths, weaknesses, risks, and protective factors in each area; ▪ A description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions, and current medications; ▪ A strengths/protective factors/problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment, and treatment and recovery history; ▪ Evidence of recipient participation, including families, or when applicable, guardians or other caregivers in the assessment, as well as discussion of results; ▪ A recommendation regarding target population eligibility [needed only for state-funded services]; ▪ An analysis and interpretation of the assessment information with an appropriate case formulation; ▪ Diagnoses on all five [5] DSM-IV-TR; and ▪ Recommendations for additional assessments, services, support, or treatment, based on the results of the comprehensive clinical assessment. A person's condition at intake may suggest that the individual has previously been in treatment. Service providers should cooperate and work together to facilitate the individual's access to services. Relevant clinical information provided by other service providers is important and should be copied and sent to the new provider in a timely manner [with the appropriate written consent] to ensure continuity of care. HIPAA regulations do not require a written release to disclose information if the purpose of the disclosure is to facilitate the individual's access to treatment or to avert a serious health/safety threat. According to the federal substance abuse confidentiality law [42 CFR], obtaining written consent for disclosure of information is not required for individuals with substance abuse issues in cases of medical emergencies; otherwise, written consent must be obtained. The comprehensive clinical assessment supports the person-centered planning process. Upon completion of the CCA process, the clinical practitioner(s) should work directly with the clinical home provider in the development of the PCP for services, natural supports, and crisis prevention activities all related to wellness management. *Disability-Specific Guidelines for the Comprehensive Clinical Assessment* *Services for Children:* In the case of children/youth and their families, the comprehensive clinical assessment should: ▪ Address the prior existence and work of the Child and Family Team [CFT] ▪ Recommend members of the Child and Family Team that the family and Qualified Professional will convene if the family is new to services ▪ Assess the strengths of the child/youth and their family and consider utilizing a strength-based assessment tool. For information on Strength-Based Assessments, go to: http://www.ncdhhs.gov/mhddsas/childandfamily/index-new.htm ▪ Utilize information such as reports from psychological testing and/or Individual Education Plans *Mental Health Services:* For all adults with a diagnosis of a major mental illness, the assessment should identify the clinical services appropriate to treat the diagnosed condition. The assessment should incorporate principles of psychoeducation, wellness and recovery, empowerment in developing an inter-dependent partnership with the individual during the diagnostic process. The

[continuation] 4A. Information gathered through assessments, person-centered description, and characteristics/ observations/ justifications for goals is incorporated into the PCP.	assessment should also identify whether there is a need for additional evaluations such as psychological testing, psychiatric evaluation, medication evaluation, or additional assessments to identify potential co-occurring diagnoses. *Developmental Disability Services:* In many cases, persons with developmental disabilities have multiple disabilities and present with complex profiles that necessitate a more comprehensive approach to addressing their needs. Since developmental disabilities are life-long conditions, the focus of the comprehensive clinical assessment is on identifying the person's current functioning status and identifying the supports needed to help the person achieve and maintain maximum independence. Such an approach often requires a variety of clinical assessments [e.g., intellectual assessment, psychiatric assessment, assessment of the individual's current level of adaptive functioning, physical examination, educational/vocational assessment, PT/OT evaluation]. A person with a developmental disability may require periodic assessments to determine ongoing needs. *Substance Abuse Services:* The information gathered in the comprehensive clinical assessment should be utilized to determine the appropriate level of care using the ASAM Patient Placement Criteria [Second Edition] as a clinical guide. The ASAM level of care recommendation should be included in the disposition of the comprehensive clinical assessment. *Other Instruments Used to Complete the Comprehensive Clinical Assessment* *Detoxification Services:* Detoxification rating scale tables, e.g., Clinical Institute Withdrawal Assessment – Alcohol, Revised [CIWA-AR], and flow sheets, which include tabulation of vital signs, are to be used as needed. See Chapter 10 – "Special Service-Specific Documentation Requirements and Provisions" – for other requirements related to detoxification services. *Driving While Impaired [DWI] Services:* The selection of instruments used in assessing DWI offenders is limited to the approved list maintained and published by DHHS. This list can be accessed at the following link: http://www.nctasc.net/ncdwiservices/providers/screenassess10-31-06revised4-3-07.doc. The assessment documentation includes a standardized test, a clinical face-to-face interview, a review of the individual's complete driving history from the Division of Motor Vehicles, Blood Alcohol Content [BAC] verification, DSM-IV-TR diagnosis, ASAM Patient Placement Criteria review, consent for release of information, client notification of provider choice, recommendations and requirements for driver's license reinstatement, and assessment data completed on DMH Form 508-R. For additional guidance, please see Chapter 10 – "Special Service-Specific Documentation Requirements and Provisions" – for other requirements related to DWI assessments and protocol. *Managing Access for Juvenile Offender Resources and Services [MAJORS]:* The MAJORS Assessment System [MAS] is a standardized assessment protocol to aid clinicians in determining the presence of a substance abuse or dependence diagnosis. All youth referred to MAJORS complete three self-report, audio-assisted modules: ▪ Substance Abuse screening [CASAA], ▪ Mental Health screening, and ▪ Readiness for Change Questionnaire [RCQ]. The CASAA helps counselors determine the presence of a substance abuse diagnosis and is intended as a supplement to a full clinical assessment. At discharge, MAJORS counselors are responsible for completing the MAJORS Services Survey [MSS] as part of the MAS. For more information on MAJORS requirements, go to the MAJORS website at the following link: http://www.ncmajors.org/main.htm. *NC-SNAP for Individuals with Developmental Disabilities:* The North Carolina Support Needs Assessment Profile [NC-SNAP] is an assessment protocol used to assess the level of intensity of services and supports needed by an individual with developmental disabilities. The NC-SNAP is required for all individuals with developmental disabilities, regardless of whether the services they are receiving are Medicaid or state-funded. The NC-SNAP is not a diagnostic tool, and it is not intended to replace any formal professional or diagnostic assessment instrument. The three domains addressed by the NC-SNAP are: ▪ Behavioral Supports; ▪ Daily Living Supports; and ▪ Health Care Supports. For more information and resources related to the NC-SNAP, please go to the following link: http://www.ncdhhs.gov/mhddsas/ncsnap/index.htm *North Carolina Treatment Outcomes and Program Performance System [NC-TOPPS]:* As previously discussed in Chapter 1 – "General Records Administration and Reporting Requirements," NC-TOPPS is the program by which DMH/DD/SAS measures outcomes and performance, It must be completed in a face-to face interview by the clinical home provider with individuals who receive mental health or substance abuse services. The NC-TOPPS is administered as a regular part of developing and updating

[continuation] 4A. Information gathered through assessments, person-centered description, and characteristics/ observations/ justifications for goals is incorporated into the PCP.	an individual's PCP to capture key information on an individual's current episode of treatment. It aids the provider in the evaluation of active treatment services, provides data for meeting federal performance and outcome measures, and supports LMEs in their responsibility for monitoring treatment services. Please see Chapter 1, which outlines in more detail the use and completion of the NC-TOPPS. In addition, the link below contains the NC-TOPPS support materials, linked here: http://nctopps.ncdmh.net/a_training.html. The web portal for NC-TOPPS data entry can be found here: http://nctopps.ncdmh.net/ *Treatment Accountability for Safer Communities [TASC]:* The assessment process for TASC includes a structured interview and a standardized instrument. The information collected and documented includes demographics, employment, education, legal, drug/alcohol use, family/social relationships, family history, medical status, psychiatric status, mental health screening, DSM-IV-TR diagnostic impression, ASAM level of care, assessment outcome, and staff signature and credentials. See Chapter 10 – "Special Service-Specific Documentation Requirements and Provisions" – for other requirements related to TASC, as well as the TASC Standard Operating Procedures Manual, found at the following link: http://northcarolinatasc.org/ *Work First/Substance Abuse Initiative:* An assessment for substance abuse issues is required for all Work First applicants/recipients; however, assessment for mental health issues is voluntary. The AUDIT and DSAT-10 shall be used for assessing alcohol and drug abuse issues for all adult Work First applicants/recipients. If the applicant/recipient is referred to a Qualified Substance Abuse Professional, the Substance Abuse Behavioral Indicator Checklist is used to document the behavioral indicators upon which the referral is based. The Emotional Health Inventory is used when assessing mental health issues for adult Work First applicant/recipients. FOR CAP-MR/DD SERVICES, PLEASE REFER TO THE CAP-MR/DD MANUAL: http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm. IMPLEMENTATION UPDATE #36: COMPREHENSIVE CLINICAL ASSESSMENT: We have received numerous questions about the function and requirements for a comprehensive clinical assessment in person centered planning. A "comprehensive clinical assessment" is not a service definition; rather it is an intensive clinical and functional face-to-face evaluation of an individual's presenting mental health, developmental disability, and/or substance abuse condition that results in the issuance of a written report, providing the clinical basis for the development of the Introductory Person Centered Plan (PCP), the Complete PCP, or the service plan when a PCP is not required. This written report also includes recommendations for services, supports, and/or treatment. Through a comprehensive clinical assessment, the information essential to formulating a diagnosis and plan of treatment is gathered…. The elements…[of] a comprehensive clinical assessment are accepted by our Divisions as meeting the standards for an initial professional assessment. The purpose of the comprehensive clinical assessment is to provide the Qualified Professional with the necessary data and recommendations to perform the analysis and synthesis of this information in the development of the PCP with the consumer. A comprehensive clinical assessment offers an opinion as to whether the consumer is appropriate for and can benefit from mental health, developmental disabilities, and/or substance abuse services. It also evaluates the consumer's level of readiness and motivation to engage in treatment and, for individuals with substance abuse conditions, recommends a level of placement using the American Society of Addiction Medicine (ASAM) Criteria. For individuals with developmental disabilities it provides a basis for identifying the comprehensive service and support needs of the consumer. [See item 4A above for the required elements of a comprehensive clinical assessment.] PERSON-CENTERED PLANNING INSTRUCTION MANUAL - 2/3/10: The crisis plan is an active and living document that is to be used in the event of a crisis. After crisis, person and staff should meet to discuss how well plan worked and make changes as indicated. A target date may never exceed 12 months from the Date of Plan. APSM 45-2: RECORDS MANAGEMENT & DOCUMENTATION MANUAL: CHAPTER 6: PERSON-CENTEREDNESS: *The Crisis Plan as a Required Component of the Person-Centered Plan*: The PCP contains a section for a Crisis Plan, which is a required component of all PCPs. A PCP is not considered complete without a Crisis Plan, except as outlined above within the context of an Introductory PCP and the Complete PCP. At a minimum, the Crisis Plan shall address the following when the PCP has been competed: ▪ Supports/interventions aimed at preventing a crisis [proactive] ▪ Supports/interventions to employ if there is a crisis [reactive] ▪ Symptoms or behaviors that may trigger the onset of a crisis ▪ Crisis prevention and early intervention strategies

[continuation] 4A. Information gathered through assessments, person-centered description, and characteristics/ observations/ justifications for goals is incorporated into the PCP.	▪ Strategies for crisis response and stabilization ▪ Specific recommendations if person arrives at the Crisis and Assessment Service ▪ All current medications ▪ Strategies for determining, after the crisis, what worked and what did not, and for making changes in the plan ▪ Contact list, including First Responder information ▪ Advance directives ▪ Crisis Plan distribution list APSM 45-2: RECORDS MANAGEMENT & DOCUMENTAION MANUAL: CHAPTER 8: SERVICE NOTES AND SERVICE GRIDS: Service notes must be written in such a way that there is substance, efficacy, and value. Interventions, treatment, and supports must all address the goal(s) listed in the service plan [the PCP or Plan of Care (POC) in most cases]. They should be written in a meaningful way so that the notes collectively outline the individual's response to treatment, interventions, and supports in a sequential, logical, and easy-to-follow manner over the course of service. SERVICE DEFINITIONS: LINKS TO ACCESS THE SPECIFIC SERVICE DEFINITIONS: DMA CLINICAL COVERAGE POLICIES 8A, 8D-1, AND 8D-2, http://www.ncdhhs.gov/dma/mp/mpindex.htm; JULY, 2005, SPECIAL MEDICAID BULLETIN FOR TARGETED CASE MANAGEMENT, http://www.ncdhhs.gov/dma/bulletin/DDTargetedCaseMgmt.pdf; DMH/DD/SA SERVICE DEFINITIONS OF 1/1/03, found here: http://www.ncdhhs.gov/mhddsas/servicedefinitions/index.htm; IMPLEMENTATION UPDATE #5: DEVELOPMENTAL THERAPY, http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/dmadmh2-23-06update5.pdf.
4B. The QP assures that the action plan of the PCP addresses what is important TO and important FOR the person [the individual's preferences & needs, including any health and safety risks) as gathered through the information listed in 4A. [continued]	PERSON-CENTERED PLANNING INSTRUCTION MANUAL - 2/3/10: Enter a person-centered measurable objective needed to achieve the long range outcome based on the What's Important To section of the dialogues/interviews. In order to protect a person's health, safety and consequently the person's freedom, it is necessary to identify his/her health and safety risk factors. These factors should be recorded in the One Page Profile, How Best to Support section. Ensure that supports and back up plans aimed at minimizing risk are addressed in the Action Plan, based on the information gathered. Risk should be addressed by helping a person look at ways to be safe within the choices made. Describe what one may observe when the person goes into crisis. Include lessons learned from previous crisis events): ▪ Include information on health and wellness issues. Are there physical medical issues that contribute to this person's vulnerability to crisis? Are there physical medical issues that need to be addressed in the wake of a crisis? ▪ Describe in detail the known behaviors a person/family may identify which indicate to others that they need to take over responsibility for that person's care and make decisions on that person's behalf. ▪ Include information on the kinds of supports that may be effective for this person. ▪ Include information on environmental factors that may contribute to the onset of crisis and how those could possibly be controlled. Include information learned from previous episodes that may contribute to the success of crisis de-escalation or crisis diversion actions ▪ Incorporate information gathered from the One Page Profile. 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN [See citation in Key Element 4A above.] SERVICE DEFINITIONS: LINKS TO ACCESS THE SPECIFIC SERVICE DEFINITIONS: DMA CLINICAL COVERAGE POLICIES 8A, 8D-1, AND 8D-2, http://www.ncdhhs.gov/dma/mp/mpindex.htm;

4B. The QP assures that the action plan of the PCP addresses what is important TO and important FOR the person [the individual's preferences & needs, including any health and safety risks) as gathered through the information listed in 4A.	JULY, 2005, SPECIAL MEDICAID BULLETIN FOR TARGETED CASE MANAGEMENT, http://www.ncdhhs.gov/dma/bulletin/DDTargetedCaseMgmt.pdf; DMH/DD/SA SERVICE DEFINITIONS OF 1/1/03, found here: http://www.ncdhhs.gov/mhddsas/servicedefinitions/index.htm; IMPLEMENTATION UPDATE #5: DEVELOPMENTAL THERAPY, http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/dmadmh2-23-06update5.pdf. FOR CAP-MR/DD SERVICES, PLEASE REFER TO THE CAP-MR/DD MANUAL: http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm
4C Individuals' crisis prevention/crisis response plans are complete.	PERSON-CENTERED PLANNING INSTRUCTION MANUAL - 2/3/10: Describe what one may observe when the person goes into crisis. Include lessons learned from previous crisis events): ▪ Include information on health and wellness issues. Are there physical medical issues that contribute to this person's vulnerability to crisis? Are there physical medical issues that need to be addressed in the wake of a crisis? ▪ Describe in detail the known behaviors a person/family may identify which indicate to others that they need to take over responsibility for that person's care and make decisions on that person's behalf. ▪ Include information on the kinds of supports that may be effective for this person. ▪ Include information on environmental factors that may contribute to the onset of crisis and how those could possibly be controlled. Include information learned from previous episodes that may contribute to the success of crisis de-escalation or crisis diversion actions ▪ Incorporate information gathered from the One Page Profile. Crisis Prevention and Intervention Plan: Strategies for crisis response and stabilization - (Focus first on natural and community supports. Begin with least restrictive steps. Include process for obtaining back-up in case of emergency and planning for use of respite, if an option. List everything you know that has worked to help this person to become stable): ▪ Provide a detailed description of strategies to be implemented to help the person/family stabilize during a crisis. Strategies should be based on knowledge, information and feedback from the person/family and other team members as well as effective intervention strategies identified during the person's day to day life and from previous crises and problem resolution. ▪ Steps should focus first on natural and community supports, starting with the least restrictive interventions. Incorporate information gathered from the One Page Profile ▪ Positive behavioral supports and approaches other than calling in law enforcement to deal with a crisis should be sought. Law enforcement should be called as a last resort only. If calling law enforcement is part of the plan, law enforcement should be involved in the plan development and their agreement determined ahead of time. Specific recommendations for interacting with the person receiving a Crisis Service: ▪ Remember, this information is for use at a Crisis Service, most likely by staff who does not know this individual/family well or at all. What do they need to know or do immediately? ▪ List specific detailed information learned from this person/family about the type of interaction and treatment that is helpful during a crisis and also the type of things that need to be avoided. ▪ Incorporate information gathered from the One Page Profile. CONTRACT BETWEEN LME AND PROVIDER AGENCY FOR STATE-FUNDED MH/DD/SA SERVICES – 6/13/07: 2.13 First Responder for Crisis/Emergency. A Provider delivering a service with defined first responder responsibilities or who are designated in the Person Centered Plan (PCP) (which will include a comprehensive crisis plan) shall act as first responder to individuals referred by the LME if and when the individual and/or a member of their support system initiates

[continuation] 4C Individuals' crisis prevention/crisis response plans are complete.	contact for assistance involving a psychiatric crisis or emergency. Only those individuals whose distress represents a clear and present danger to self or others, and/or those individuals whose level of distress is not alleviated following reasonable efforts, shall be referred to the LME's crisis service. Provider shall notify the individual and his/her support system of the process for accessing crisis/emergency services 24 hours a day, 7 days a week, 365 days a year, both orally and in writing at initial contact. The notification shall include contact information for an alternate source of assistance in the eventuality that Provider is not available. Crisis services do not require prior authorization from the LME. AGREEMENT BETWEEN LME AND DIRECT-ENROLLED PROVIDERS OF ENHANCED MH/DD/SA SERVICES FOR MEDICAID – UPDATED 5/15/06: 2.14 First Responder for Crisis/Emergency. If Provider is delivering a service with defined first responder responsibilities or who are designated in the Person Centered Plan (PCP) (which will include a comprehensive crisis plan) shall act as first responder to individuals referred by Area Authority/County Program if and when the individual and/or a member of their support system initiates contact for assistance involving a psychiatric crisis or emergency. Only those individuals whose distress represents a clear and present danger to self or others, and/or those individuals whose level of distress is not alleviated following reasonable efforts, shall be referred to Area Authority/County Program's crisis service. Provider shall notify the individual and his/her support system of the process for accessing crisis/emergency services 24 hours a day, 7 days a week, 365 days a year, both orally and in writing at initial contact. The notification shall include contact information for an alternate source of assistance in the eventuality that Provider is not available. Crisis services do not require prior authorization from Area Authority/County Program. FOR ACCESS TO THE FULL PCP INSTRUCTION MANUAL, GO TO: http://www.ncdhhs.gov/mhddsas/pcp.htm. FOR CAP-MR/DD SERVICES, PLEASE REFER TO THE CAP-MR/DD MANUAL: http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm
4D. The QP monitors implementation of the PCP, revises the plan when needed and required, and involves the individual/family/ Legally responsible person in the process.	FOR ACCESS TO THE FULL PCP INSTRUCTION MANUAL, GO TO: http://www.ncdhhs.gov/mhddsas/pcp.htm. FOR CAP-MR/DD SERVICES, PLEASE REFER TO THE CAP-MR/DD MANUAL: http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm APSM 45-2: RECORDS MANAGEMENT & DOCUMENTAION MANUAL: CHAPTER 6: PERSON-CENTEREDNESS: *Review and Revision of the Person-Centered Plan:* At a minimum, the PCP shall be rewritten annually, based on the date the PCP was valid for billing. [See below for more information regarding validity of the PCP]. However, the expectation is that the PCP will be reviewed and updated more frequently, due to the changing needs of the individual served. The PCP must be reviewed and revised whenever the following situations occur: ▪ The target date assigned to each goal is due to expire and is in need of review; ▪ The individual's needs change and a new service is being requested; ▪ The individual's needs change and an existing service is being reduced or terminated; ▪ The individual's needs change and goals needs to be revised, added, or terminated; ▪ The designated service provider changes; or ▪ It is time for the annual rewrite of the PCP, based on the date the PCP was valid for billing. SERVICE DEFINITIONS: LINKS TO ACCESS THE SPECIFIC SERVICE DEFINITIONS: DMA CLINICAL COVERAGE POLICIES 8A, 8D-1, AND 8D-2, http://www.ncdhhs.gov/dma/mp/mpindex.htm; JULY, 2005, SPECIAL MEDICAID BULLETIN FOR TARGETED CASE MANAGEMENT, http://www.ncdhhs.gov/dma/bulletin/DDTargetedCaseMgmt.pdf; DMH/DD/SA SERVICE DEFINITIONS OF 1/1/03, found here: http://www.ncdhhs.gov/mhddsas/servicedefinitions/index.htm; IMPLEMENTATION UPDATE #5: DEVELOPMENTAL THERAPY, http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/dmadmh2-23-06update5.pdf.

4E Services are implemented according to the plan and service definitions.	FOR ACCESS TO THE FULL PCP INSTRUCTION MANUAL, GO TO: http://www.ncdhhs.gov/mhddsas/pcp.htm. FOR CAP-MR/DD SERVICES, PLEASE REFER TO THE CAP-MR/DD MANUAL: http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm SERVICE DEFINITIONS: LINKS TO ACCESS THE SPECIFIC SERVICE DEFINITIONS: DMA CLINICAL COVERAGE POLICIES 8A, 8D-1, AND 8D-2, http://www.ncdhhs.gov/dma/mp/mpindex.htm; JULY, 2005, SPECIAL MEDICAID BULLETIN FOR TARGETED CASE MANAGEMENT, http://www.ncdhhs.gov/dma/bulletin/DDTargetedCaseMgmt.pdf; DMH/DD/SA SERVICE DEFINITIONS OF 1/1/03, found here: http://www.ncdhhs.gov/mhddsas/servicedefinitions/index.htm; IMPLEMENTATION UPDATE #5: DEVELOPMENTAL THERAPY, http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/dmadmh2-23-06update5.pdf.
4F The provider communicates with other providers for continuity of care.	FOR ACCESS TO THE FULL PCP INSTRUCTION MANUAL, GO TO: http://www.ncdhhs.gov/mhddsas/pcp.htm. FOR CAP-MR/DD SERVICES, PLEASE REFER TO THE CAP-MR/DD MANUAL: http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm APSM 45-2: RECORDS MANAGEMENT & DOCUMENTATION MANUAL: CHAPTER 2: THE CLINICAL SERVICE RECORD: http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/index.htm SERVICE DEFINITIONS: LINKS TO ACCESS THE SPECIFIC SERVICE DEFINITIONS: DMA CLINICAL COVERAGE POLICIES 8A, 8D-1, AND 8D-2, http://www.ncdhhs.gov/dma/mp/mpindex.htm; JULY, 2005, SPECIAL MEDICAID BULLETIN FOR TARGETED CASE MANAGEMENT, http://www.ncdhhs.gov/dma/bulletin/DDTargetedCaseMgmt.pdf; DMH/DD/SA SERVICE DEFINITIONS OF 1/1/03, found here: http://www.ncdhhs.gov/mhddsas/servicedefinitions/index.htm; IMPLEMENTATION UPDATE #5: DEVELOPMENTAL THERAPY, http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/dmadmh2-23-06update5.pdf. CONTRACT BETWEEN LME AND PROVIDER AGENCY FOR STATE-FUNDED MH/DD/SA SERVICES – 6/13/07: 2.3 Service Coordination: Continuity of care is expected for all individuals served under this Contract. In an effort to improve the coordination of supports and services within the LME's community of providers, Provider agrees to use good faith efforts to coordinate supports and services with other Provider participants, Carolina Access and other primary care providers for all individuals served under this Contract. The Provider shall obtain appropriate client authorizations and consents to release or exchange information. The Provider shall participate in team meetings and/or community collaborations and communicate regularly with other providers regarding mutual cases. The primary service provider who engages an Independent Practitioner (a directly enrolled clinician providing outpatient therapy) to serve consumers receiving benefits will maintain a contract with the Independent Practitioner to ensure care coordination. Providers who act as the clinical home such as those delivering Community Support, Community Support Team or Targeted Case Management Services must either provide or subcontract for psychiatric services when consumers need them. A pattern of failure to coordinate services in a timely manner, without demonstrated corrections may result in contract termination. AGREEMENT BETWEEN LME AND DIRECT-ENROLLED PROVIDERS OF ENHANCED MH/DD/SA SERVICES FOR MEDICAID – UPDATED 5/15/06: 2.5 Service Coordination: For purposes of this Agreement, "provider participant" shall refer to all service providers to whom the Area Authority/County Program refers consumers. Continuity of care is expected for all individuals served under this Agreement. In an effort to improve the coordination of supports and services within the Area Authority/County Program's community of providers, Provider agrees to use good faith efforts to coordinate supports and services with other provider participants, Carolina Access and other primary care providers for all individuals served under this Agreement. The Provider shall obtain appropriate client authorizations and consents to release or exchange information. The Provider shall endeavor to

[continuation] 4F The provider communicates with other providers for continuity of care.	participate in team meetings and/or community collaborations and communicate regularly with other providers regarding mutual cases. The primary service provider who engages an Independent Practitioner (a directly enrolled clinician providing outpatient therapy) to serve consumers receiving enhanced benefits will maintain a MOA/or a contract with the Independent Practitioner to ensure care coordination. Providers who act as the clinical home such as those delivering Community Support, Community Support Team or Targeted Case Management Services must either provide or arrange and coordinate appropriate psychiatric services when consumers need them.
4G The provider identifies and addresses individual changing needs & communicates with the QP responsible for writing the plan when needed. [continued] 4G The provider identifies and addresses individual changing needs & communicates with the QP responsible for writing the plan when needed.	FOR ACCESS TO THE FULL PCP INSTRUCTION MANUAL, GO TO: http://www.ncdhhs.gov/mhddsas/pcp.htm. FOR CAP-MR/DD SERVICES, PLEASE REFER TO THE CAP-MR/DD MANUAL: http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm SERVICE DEFINITIONS: LINKS TO ACCESS THE SPECIFIC SERVICE DEFINITIONS: DMA CLINICAL COVERAGE POLICIES 8A, 8D-1, AND 8D-2, http://www.ncdhhs.gov/dma/mp/mpindex.htm; JULY, 2005, SPECIAL MEDICAID BULLETIN FOR TARGETED CASE MANAGEMENT, http://www.ncdhhs.gov/dma/bulletin/DDTargetedCaseMgmt.pdf; DMH/DD/SA SERVICE DEFINITIONS OF 1/1/03, found here: http://www.ncdhhs.gov/mhddsas/servicedefinitions/index.htm; IMPLEMENTATION UPDATE #5: DEVELOPMENTAL THERAPY, http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/dmadmh2-23-06update5.pdf.

[End of Worksheet 4]

KEY ELEMENTS	CITATIONS
5A. The provider informs individuals and legally responsible persons about the process for filing a grievance /complaint and is open to and/or responsive to complaints.	10A NCAC 27D .0201 INFORMING CLIENTS (d) In each facility, the information provided to the client or legally responsible person shall include; (4) governing body policy regarding: (B) grievance procedures including the individual to contact and a description of the assistance the client will be provided; 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (18) client grievance policy, including procedures for review and disposition of client grievances. 10A NCAC 27G .0601 SCOPE (a) This Section governs Local Management Entity (LME) monitoring of the provision of public services in the LME's catchment area. (b) The LME shall monitor the provision of public services in the LME's catchment area. (c) The LME shall develop and implement written policies governing monitoring of the provision of public services that include: (1) receiving, reviewing and responding to level II and level III incident reports as set forth in Rules .0603, .0604, and .0605 of this Section; (2) receiving and responding to complaints concerning the provision of public services, as set forth in Rule .0606 of this Section; (3) conducting local monitoring of Category A and B providers of public services as set forth in Rule .0608 of this Section; and (4) analyzing and reporting trends in the information identified in Subparagraphs (c)(1) through (c)(3) of this Rule, as set forth in Rule .0608 of this Section. (d) An LME or provider of public services shall exchange information, including confidential information, when necessary to coordinate and carry out the monitoring functions as set forth in this Section. Sharing of information shall conform to 42 CFR, Part 2 for persons receiving Substance Abuse Services. The exchange of information shall apply as follows: (1) an LME to another LME; (2) an LME to a provider of public services; (3) a provider of public services to an LME; (4) a provider of public services to another provider of public services; (5) a provider of public services to the Department; (6) an LME to the Department; (7) the Department to an LME; and (8) the Department to a provider of public services. 10A NCAC 27G .7002 LOCAL MANAGEMENT ENTITY REQUIREMENTS CONCERNING COMPLAINTS (a) A Local Management Entity shall respond to complaints received concerning the provision of public services pertaining to all provider categories, as defined in 10A NCAC 27G .0602(8), in its catchment area. This Rule does not govern complaints pertaining to utilization review decisions. (b) The Local Management Entity shall: (1) establish a written notification procedure to inform each client of the complaint process concerning the provision of public services. The procedure shall include the provision of written information explaining the client's right to contact the Local Management Entity, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the Division of Health Service Regulation, the Division of Social Services and The North Carolina Protection and Advocacy system known as Disability Rights North Carolina; (2) seek to resolve issues of concern through informal agreement between the client and the provider and document the attempts at resolution; (3) develop and implement written policies including those safeguards and procedures listed below: (A) safeguards for protecting the identity of the complainant; (B) safeguards for protecting the complainant and any staff person from harassment or retaliation; (C) procedures to receive and track complaints; (D) procedures to assist a client in initiating the complaint process; (E) procedures for encouraging the complainant to communicate with the provider to allow for resolution of the issue;

[continuation]

(F) methods to be used in investigating a complaint;
(G) procedures for responding to complaints and options to be considered in resolving a complaint, including corrective action and referral to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the Division of Health Service Regulation, the Division of Social Services or other agencies as required;
(H) procedures governing complaints and appeals made by a provider and a complainant;
(I) procedures for notifying the home Local Management Entity, if different, of the complaint and actions taken; and
(J) procedures for the Local Management Entity Director to convene an ad hoc appeal review committee to review client and provider appeals. The client rights committee, as defined in 10A NCAC 27G .0504, shall approve policy and procedures regarding the formation of the appeal review committee including assurance of the review committee's lack of conflict of interest, composition, disability affiliation(s) and other experience or qualifications relevant to the issue(s) in the complaint. The committee's recommendations shall be by majority vote;

(4) review the complaint and communicate to the complainant within five working days of receipt whether the complaint will be addressed informally or by conducting an investigation; and
(5) notify the complainant in writing of the results of the informal process in a letter dated within 15 working days from
(6) receipt of the complaint. If the need for an investigation is revealed during the informal process, the Local Management Entity shall begin the investigation or refer the matter to the appropriate State or local government agency. If the complainant is not satisfied with the informal process, the complainant may file an appeal in writing to the Local Management Entity Director. The appeal must be received within 15 working days from the date of the informal resolution letter. The Local Management Entity Director shall:

(A) convene an appeal review committee according to Part (b)(3)(J) of this Rule; and
(B) issue an independent decision after reviewing the appeal review committee's recommendation. The decision shall be dated and mailed to the appellant by the Local Management Entity within 20 working days from receipt of the appeal.

5A.

The provider informs individuals and legally responsible persons about the process for filing a grievance /complaint and is open to and/or responsive to complaints.

(c) When the Local Management Entity refers the complaint to the State or local government agency responsible for the regulation and oversight of the provider, the Local Management Entity shall send a letter to the complainant informing him or her of the referral and the contact person at the agency where the referral was made. The Local Management Entity shall contact the State or local government agency where the referral was made within 80 working days of the date the Local Management Entity received the complaint to determine the actions the State or local government agency has taken in response to the complaint. The Local Management Entity shall communicate the status of the State or local government agency's response to the complainant and to the client's home Local Management Entity, if different.

10A NCAC 27G .7003 REQUIREMENTS FOR LOCAL MANAGEMENT ENTITY COMPLAINT INVESTIGATIONS

(a) The Local Management Entity shall follow these procedures when investigating providers according to 10A NCAC 27G .0606:

(1) The Local Management Entity shall make contact with the provider when investigating a complaint. The Local Management Entity shall state the purpose of the contact and inform the provider that the Local Management Entity is in receipt of a complaint concerning the provider and the general nature of the complaint.
(2) The Local Management Entity shall complete the complaint investigation within 30 calendar days of the date of the receipt of the complaint.
(4) Upon completion of the complaint investigation, the Local Management Entity shall submit a report of investigation findings to the complainant,
the provider and client's home Local Management Entity, if different. The report shall be submitted within 15 calendar days of the date of completion of the investigation. The complaint investigation report shall include:
(A) statements of the allegations or complaints lodged;
(B) steps taken and information reviewed to reach conclusions about each allegation or complaint;
(C) conclusions reached regarding each allegation or complaint;
(D) citations of statutes and rules pertinent to each allegation or complaint; and
(E) required action regarding each allegation or complaint.
(4) The provider shall submit a plan of correction to the Local Management Entity for each issue requiring correction identified in the report in a letter dated 15 calendar days from the date the provider receives the complaint investigation report.
(5) The Local Management Entity shall review and respond in writing to the provider's plan of correction with approval or a description of additional required information. The Local Management Entity shall respond to the provider in a letter dated 15 calendar days of receipt of the plan of correction.
(6) The provider shall implement a plan of correction within 60 calendar days from the date of the complaint investigation report.

[continuation] 5A. The provider informs individuals and legally responsible persons about the process for filing a grievance /complaint and is open to and/or responsive to complaints.	(8) The complainant or provider who disagrees with the results of the Local Management Entity actions may file an appeal regarding the investigation that is received by the Local Management Entity within 21 calendar days from the receipt of the Local Management Entity investigation report. The Local Management Entity shall provide notification of the appeal to the complainant or provider to inform them of this appeal. The appeal is limited to items identified in the original complaint record and the investigation report. (8) The Local Management Entity shall convene a review committee to review the appeal as specified in 10A NCAC 27G .7002(b)(3)(J). (13) The Local Management Entity Director shall issue a written decision based on the appeal committee's decision to uphold or overturn the findings of the investigation. The decision letter shall be dated within 28 calendar days from receipt of the appeal. (14) The Local Management Entity shall follow-up on issues requiring correction in the investigation report no later than 60 calendar days from the date the plan of correction is approved. (15) When a complaint investigation involving a category B provider identifies an issue which if substantiated by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services could result in a revocation or suspension of the provider's funding pursuant to 10A NCAC 26C .0501 through .0504, the LME shall document the issue or issues creating the concern and notify the Division of Mental Health, Developmental Disabilities and Substance Abuse Services of the issue within 24 hours. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services shall consult with the Local Management Entity and then shall determine which agency will lead the investigation and which agencies need to be involved. Separate complaint investigations shall not be performed. (16) Local Management Entity shall provide information regarding the disposition of the complaint to the complainant and the client's home Local Management Entity, if different, as soon as the investigation is concluded. (b) The Local Management Entity shall maintain copies of complaint investigations, resolutions and follow-up reports for providers for review by the Department of Health and Human Services.
5B. Individuals are informed of their rights in a manner suited to their learning style and level of comprehension.	10A NCAC 27D .0102 : SUSPENSION AND EXPULSION POLICY: [See citation in Key Element 1E in Worksheet 1 above.] 10A NCAC 27D .0103 SEARCH AND SEIZURE POLICY [See citation in Key Element 1E in Worksheet 1 above.] 10A NCAC 27D .0201 INFORMING CLIENTS [See citation in Key Element 1E in Worksheet 1 above.] 10A NCAC 27D .0301 SOCIAL INTEGRATION [See citation in Key Element 1E in Worksheet 1 above.] 10A NCAC 27D .0302 CLIENT SELF-GOVERNANCE [See citation in Key Element 1E in Worksheet 1 above.]. 10A NCAC 27D .0303 INFORMED CONSENT [See citation in Key Element 1E in Worksheet 1 above.] 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION [See citation in Key Element 1E in Worksheet 1 above.]
5C. The provider has a system for accounting and safeguarding individuals' funds and possessions.	**SPECIFIC RULES FOR 24-HOUR FACILITIES:** 10A NCAC 27F .0104 STORAGE AND PROTECTION OF CLOTHING AND POSSESSIONS [See citation in Key Element 1E in Worksheet 1 above.] 10A NCAC 27E .0105 PROTECTIVE DEVICES [See citation in Key Element 1E in Worksheet 1 above.]

5D. Use of restrictive interventions balance individual rights with risk to individual and/or others.	10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT, ISOLATION TIME-OUT & PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL [See citation in Key Element 1E in Worksheet 1 above.] 10A NCAC 27E .0105 PROTECTIVE DEVICES [See citation in Key Element 1E in Worksheet 1 above.]

[End of Worksheet 5]